

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18								Reg. Dist. No. 00526		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 4 Min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hosp.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) LERoy		First	Middle	Last	4. DATE OF DEATH Jan. 1, 1960		Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 29, 1887		9. AGE (In years from birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Govt.			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Info.				14. MOTHER'S MAIDEN NAME Wilhelmina Allen				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes, no, or unknown)</small>				16. SOCIAL SECURITY NO. 213-12-7973		17. INFORMANT Mrs. Laura Allen Ches. City, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Embolus DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 Hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		Jan. 2, 1960				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 4, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Nr. Chesapeake City, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR Jan. 6, 1960		24b. REGISTRAR'S SIGNATURE John S. Keay				

DEPARTMENT OF STATE - DIALECTIC OF THE
WEIGHTS AND MEASURES CERTIFICATE OF DEAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G262 5/12/60 IWK

6440396
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
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1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 11 mos 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 405 Seagull Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY		First (NMI)	Middle BACOTE
4. DATE OF DEATH January unknown 1960 ?	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-13-32
9. AGE (In years less birthday) 28	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Abbutts Bacote		14. MOTHER'S MAIDEN NAME Rebecca Manning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW - Korean	17. INFORMANT Mrs. Abbutts Bacote, Mother, 1717 Howard St., Hartsville, S. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned			
929.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Unknown		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown	
20c. TIME OF INJURY Hour a. m. p. m. Unk.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unk.
20f. (City or town) Unk.	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. DODSON		DATE SIGNED 5-3-60	
EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/4/60	22b. DATE THEREOF 5/4/60	22c. NAME OF CEMETERY OR CREMATORIUM Unknown	22d. LOCATION (City, town, or county) Hartsville, S. C.
23. FUNERAL DIRECTOR'S SIGNATURE Washington, Havre de Grace, Md.	ADDRESS Washington, Havre de Grace, Md.	24a. REC'D BY REGISTRAR DATE MAY 9 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		0547		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Elkton		c. LENGTH OF STAY IN 1b 14 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rte. # 40				d. STREET ADDRESS / Rte. # 40		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HULDA	Middle S.	Last BOLLENBACHER	4. DATE OF DEATH Month January	Day 18	Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan 21, 1891	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Schnieder		14. MOTHER'S MAIDEN NAME No Info.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Edward Bollenbacher		Address Nr. Elkton, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accute Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Immediate							
260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Diabetes					
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R. C. Dodson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED Jan. 18, 1960
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 21, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Gilpin Manor Mem. Park	22d. LOCATION (City, town, or county) Nr. Elkton, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME	ADDRESS <i>In 2nd fl. Rte Elkton, Md</i>	24a. REC'D BY REGISTRAR JAN 20 '60	24b. REGISTRAR'S SIGNATURE <i>C. J. Kraus</i>				

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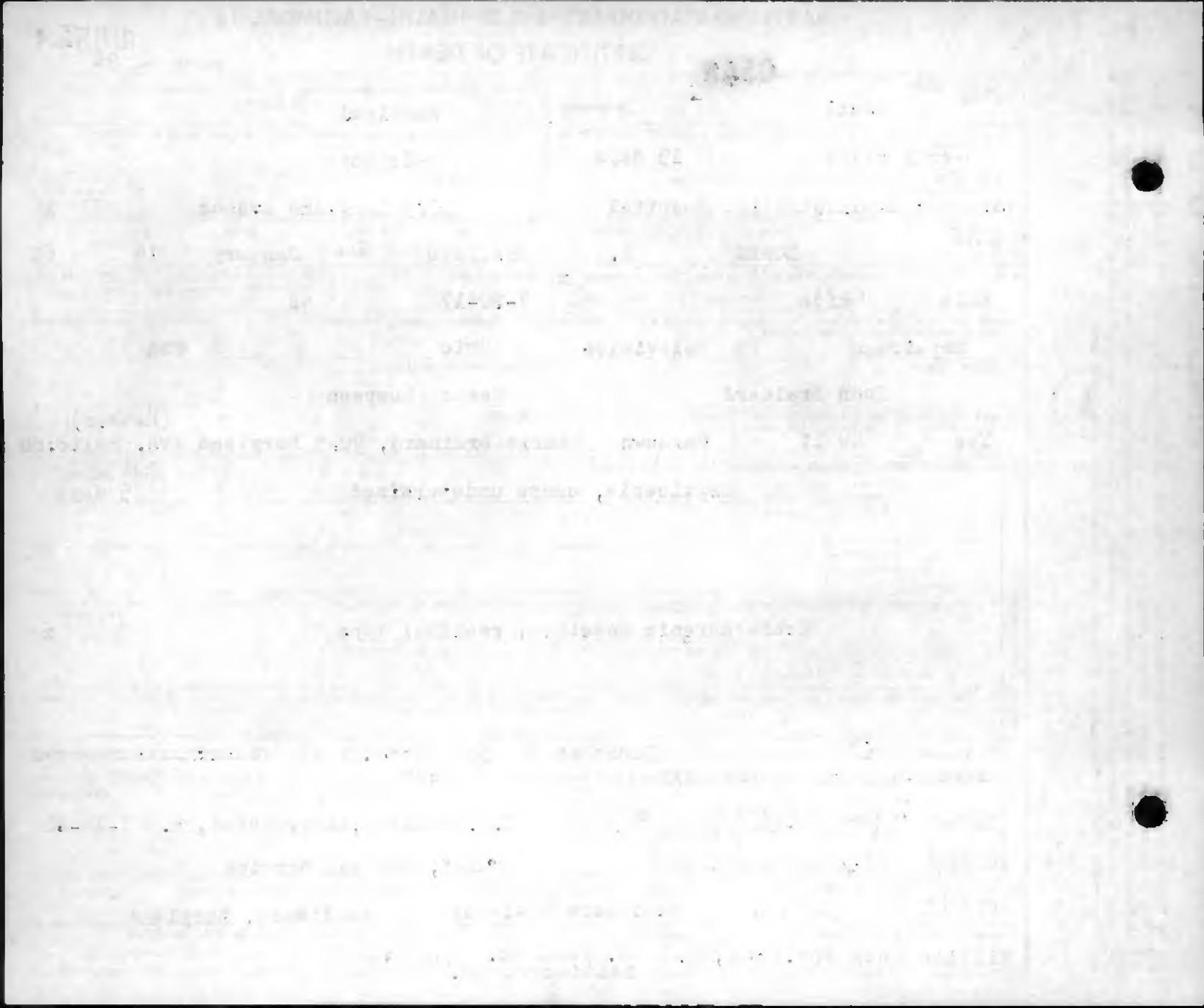
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

00528

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LOREN	Middle A.	Last BRAINARD
4. DATE OF DEATH	Month January	Day 14	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-17
9. AGE (In years last birthday) 42 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman	11. KIND OF BUSINESS OR INDUSTRY Television	12. BIRTHPLACE (State or foreign country) Ohio
13. FATHER'S NAME John Brainard	14. MOTHER'S MAIDEN NAME Essie Thompson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW II	INFORMANT Essie Brainard, 2025 Maryland Ave., Baltimore, Md.	Address (Mother)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia, cause undetermined DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic Reaction, residual type			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 30, 1959 , to January 14, 1960 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SEYMOUR GOLDGRABEN ACTUAL SIGNATURE Seymour Goldgraben, M.D. DATE SIGNED 1-14-60			
22a. BURIAL, CREMATION, BURIAL (Specify) BURIAL		22b. DATE THEREOF 1-18-60	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook Fun. Home, 1217 St. Paul St.		ADDRESS Baltimore, Md.	24a. REC'D BY REGISTRAR JAN 18 '60
			24b. REGISTRAR'S SIGNATURE Albert S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00529

CERTIFICATE OF DEATH

Reg. Dist. No.

0530

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 15yrs						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton						
3. NAME OF DECEASED (Type or print) JOHN		First G.	Middle CANN					
4. DATE OF DEATH January 19	Month January	Day 19	Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 3, 1880					
9. AGE (In years (1st birthday) yrs. 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. KIND OF BUSINESS OR INDUSTRY Retired	12. BIRTHPLACE (State or foreign country) Fair Hill, Maryland					
13. FATHER'S NAME Gilbert CANN	14. MOTHER'S MAIDEN NAME MARY Steele	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 110					
17. INFORMANT Mrs. Mary Bowlsbey, 230 W. Main St,		Address Elkton, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic hypertensive cardiovascular disease (c)								
INTERVAL BETWEEN ONSET AND DEATH 1 week								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.	Month Jan.	Day 15	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Elkton	(County) Maryland	(State) 1960
21. I certify that I attended the deceased from Jan. 15, 1959 , to Jan. 19, 1960 , that I last saw the deceased alive on Jan. 18, 1960 , and that death occurred at 2:20 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 233 E. Main Street		DATE SIGNED 1/19/60		
ACTUAL SIGNATURE <i>S. Ralph Andrews, Jr.</i>	PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton		Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/22/60	22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cemetery	22d. LOCATION (City, town, or county) Lewisville, Cecil, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph E. Hicks</i>	ADDRESS Elkton, Md.	24a. REC'D BY REGISTRAR DATE JAN 28 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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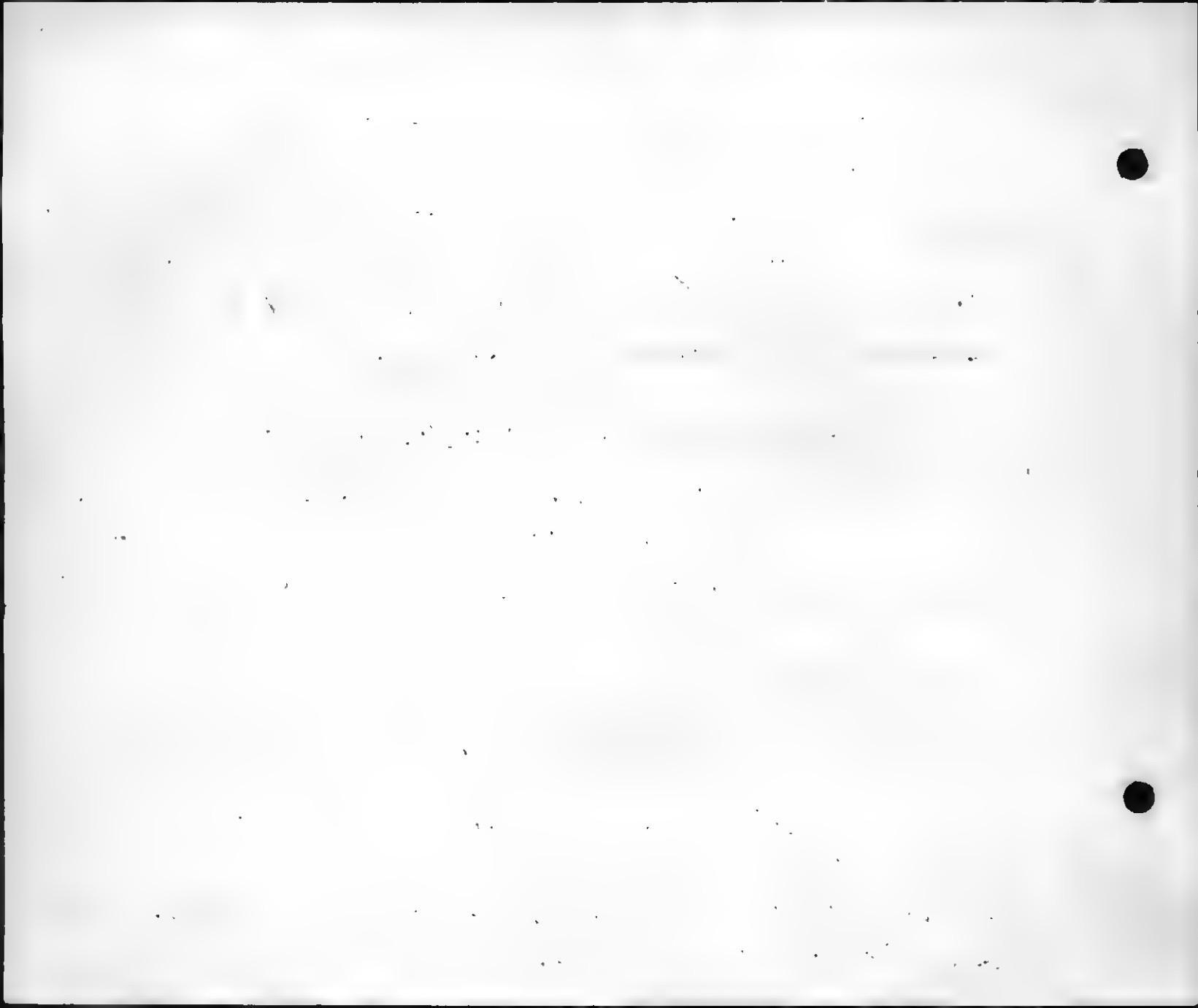
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
											Reg. Dist. No. 011530
1. PLACE OF DEATH a. COUNTY <i>Cecil</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elikton</i> c. LENGTH OF STAY IN 1b <i>1 Day</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>United Hospital</i>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's Co.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Conowingo, Rural</i> d. STREET ADDRESS <i>Conowingo Rd.</i>							
3. NAME OF DECEASED (Type or print) <i>Wilford Lester</i>				First	Middle	Last		4. DATE OF DEATH	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 7 1902</i>	9. AGE (In years last birthday) <i>50</i>	10. IF UNDER 1 YEAR Months <i>5</i>	11. IF UNDER 24 HRS. Days <i>18</i>	12. IF UNDER 24 HRS. Hours <i>10</i>	13. IF UNDER 24 HRS. Min <i>00</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Conowingo, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>William P. Carr</i>				14. MOTHER'S MAIDEN NAME <i>Deliah Harmon</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>Yes</i> <i>Unknown</i>				16. SOCIAL SECURITY NO <i>28-05-3348</i>	INFORMANT <i>William P. Carr</i>	Address <i>Conowingo Md</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture abdominal aortic aneurysm</i> DUE TO <i>451X</i> INTERVAL BETWEEN ONSET AND DEATH <i>21 hrs.</i>											
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aneurysm descending aorta</i> DUE TO <i>unknown</i> (c) <i>Atherosclerosis, generalized, severe</i> DUE TO <i>unknown</i>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>Md.</i>	(State) <i>Md.</i>			
21. I certify that I attended the deceased from <i>July 11, 1960</i> , to <i>July 12, 1960</i> , that I last saw the deceased alive on <i>July 11, 1960</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above											
ADDRESS (Street, city or town, state) <i>ADDRESS</i> DATE SIGNED <i>DATE SIGNED</i>											
ACTUAL SIGNATURE <i>Wilford Lester</i> M.D. <i>123 2nd St. Bldg. 14th & E.</i>											
PHYSICIAN'S NAME (Type) <i>William P. Johnson</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>1-15-1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Pleasant Grove Cemetery, Peach Bottom, Pa.</i>	22d. LOCATION (City, town, or county) <i>(State)</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jemon E. McMullen</i>				ADDRESS <i>Rising Sun, Md.</i>	24a. REC'D BY REGISTRAR <i>Arthur L. Evans</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	DATE <i>JAN 15 '60</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00531

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		0543		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,		c. LENGTH OF STAY IN lb 2hrs. 50min.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Box 645N		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DAVID		First D.	Middle CHASE	Last January	Month 22 Day 19 Year 60
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1891	9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME WILLIAM CHASE		14. MOTHER'S MAIDEN NAME MARY DENNISON		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Lotti Chase, Wife, Box 645, Magnolia, Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH Unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R. C. Dodson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED January 23, 1960
EXAMINER'S NAME (Type) R. C. DODSON, M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer Baptist Church	22d. LOCATION (City, town, or county) Joppa, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOWARD K. MC COMAS & SON, Abingdon, Maryland	ADDRESS		24a. REC'D BY REGISTRAR Arthur S. Kraus	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE JAN 27 '60					

TO HOSPITAL OR *ENDING PHYSICIAN:* The law requires that the d-
may be retained by hospital or attending physician.
TO FUNERAL DIR *Q: After this certificate has been signed by the*
Permit
Prob 3 signed

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 File G225 1-27-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

96

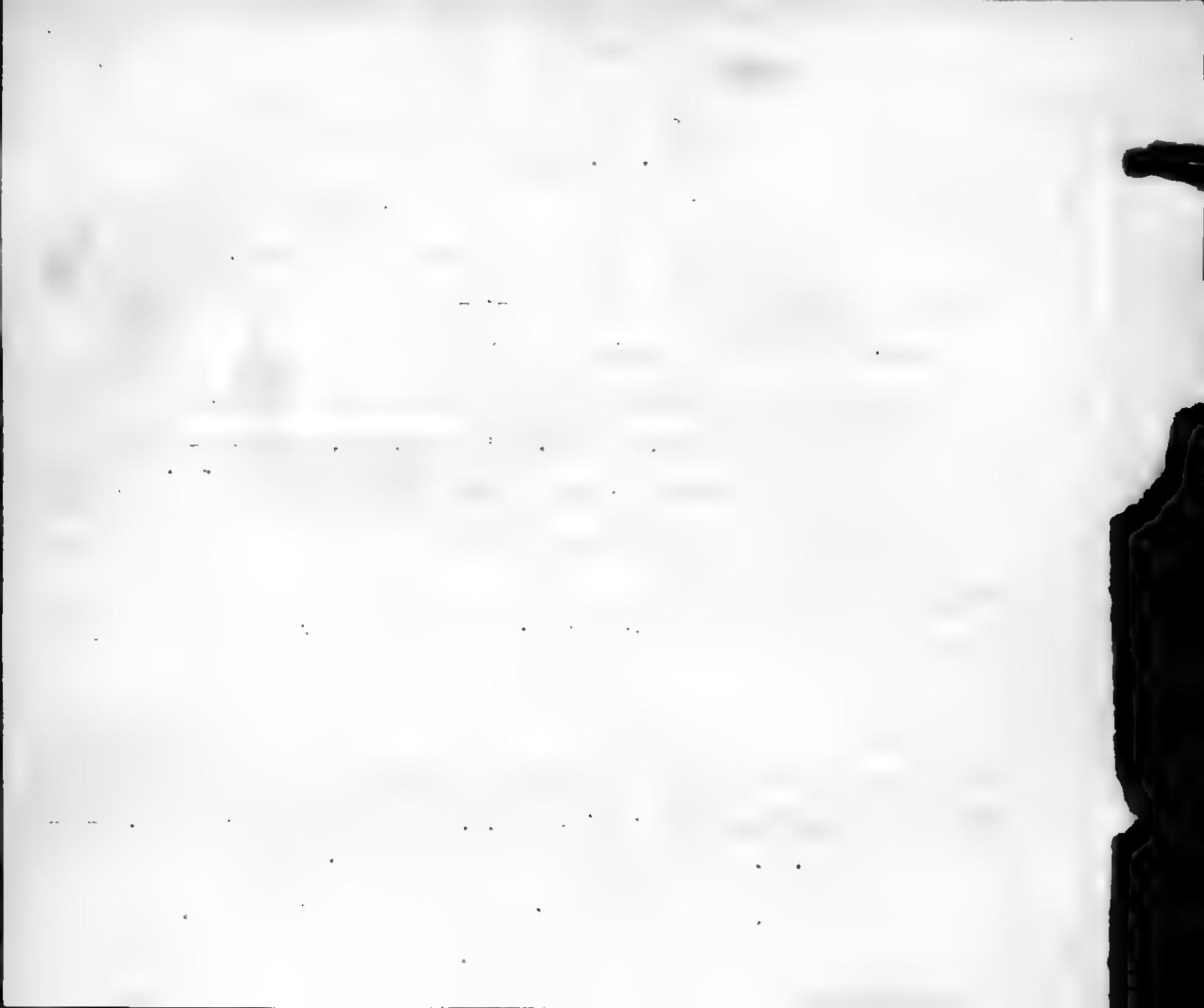
00532

1. PLACE OF DEATH a. COUNTY		0550 Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Michigan	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 34 yrs. 6 mo. 16 days		b. COUNTY Muskegon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 40 Lyman Block		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-23-89		9. AGE (In years last birthday) 70 yrs.		10. DATE OF DEATH January 11 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (State or foreign country) Hungary	
13. FATHER'S NAME Not available from records		14. MOTHER'S MAIDEN NAME Not available from records		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I Unknown		INFORMANT Mr. Fabian Tancibok, Brother-in-law, 3627	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Arteriosclerotic heart disease		Brehms Lane, Balto. Md. INTERVAL BETWEEN ONSET AND DEATH 7-10 days	
DUE TO (c)				unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Arteriosclerosis generalized severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> attended the deceased from June 26, 1925, to January 11, 1960, and that death occurred at 2:40 a.m. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE J. L. Garey				M.D. V.A. Hospital, Perry Point, Md. 1-12-60	
PHYSICIAN'S NAME (Type) J. L. GAREY				Clinical Pathologist	
22a. BURIAL, CREMATION REMOVAL (Specify Removal)		22b. DATE THEREOF 1/14/60		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	
22d. LOCATION (City, town, or county) Baltimore, Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS , Havre de Grace, Md.		24a. REC'D BY REGISTRAR JAN 18 '60	
				24b. REGISTRAR'S SIGNATURE Curtis S. Kline	

Death certificate to be executed within 24 hours after death. Physician and completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

55

be detained
in case of
removal
prior to
burial, crema-



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

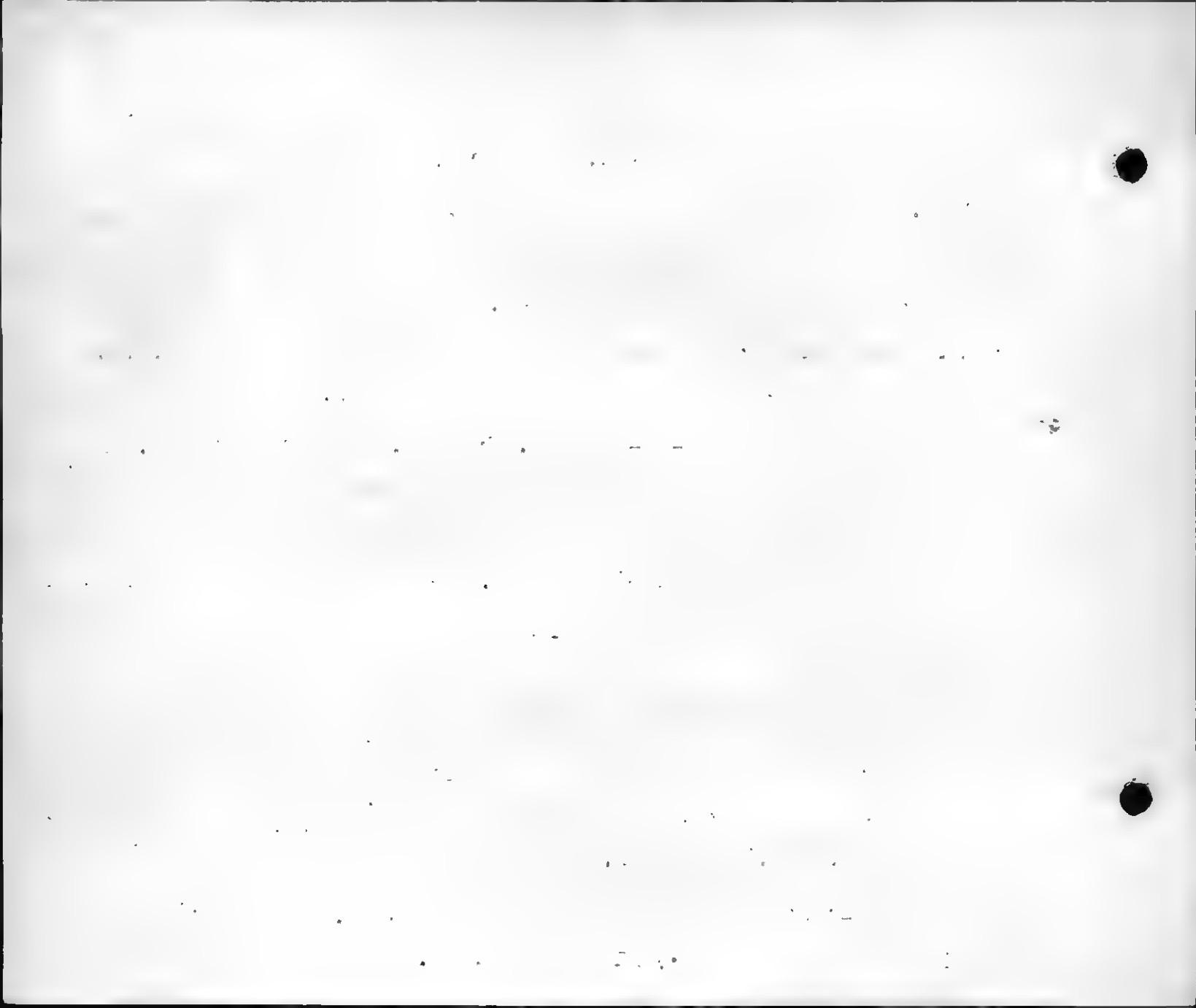
00533

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 11 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 W. Main Street,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
3. NAME OF DECEASED (Type or print) Violet Miriam		First Cook	Middle Lost
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 20, 1896
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Sales-Bakery		10b. KIND OF BUSINESS OR INDUSTRY Bakery	11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME George Terry		14. MOTHER'S MAIDEN NAME Ann No Info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 202-07-8819	INFORMANT Mr. Irvin J. Cook, Elkton, Md.
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH INSTANT.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Acute Coronary	
DUE TO Chronic (Recurrent) Arteriosclerotic Heart Disease		10 yrs	
DUE TO Acute Pleurisy		5 days	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9 JAN , 1960, to 14 JAN , 1960, that I last saw the deceased alive on 13 JAN , 1960, and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George J. Kreis, Jr.</i>		ADDRESS (Street, city or town, state) Elkton, Md.	
PHYSICIAN'S NAME (Type) George J. Kreis, Jr.		DATE SIGNED 17 Jan 60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-18-60	22c. NAME OF CEMETERY OR CREMATORIUM Immaculate Conception nr. Elkton, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Donald J. Kee Elkton, Md.	24a. REC'D BY REGISTRAR JAN 20 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Knad



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00534

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 17 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter		First W	Middle Cook	4. DATE OF DEATH January	Month 5	Day 1960	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1889	9. AGE (In years at birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Cook		14. MOTHER'S MAIDEN NAME No information					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Sophia Nowak Cook, North East (Rural) Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		CardioVascular Failure		INTERVAL BETWEEN ONSET AND DEATH 15 min			
(b) DUE TO DUE TO (c)		Bronchopneumonia		2 days			
		Pulmonary Edema		5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension CardioVascular Dis.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1959, to Jan 5th, 1960, that I last saw the deceased alive on Jan 4th, 1960, and that death occurred at 5:15 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Luis M. Cuza						DATE SIGNED	
PHYSICIAN'S NAME (Type) Luis M. Cuza							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 9, 1960		22c. NAME OF CEMETERY OR CREMATORIUM New Immaculate Conception Cem. Elkton Road		22d. LOCATION (City, town, or county) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE JAN 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0534

CERTIFICATE OF DEATH

Reg. Dist. No.

00555

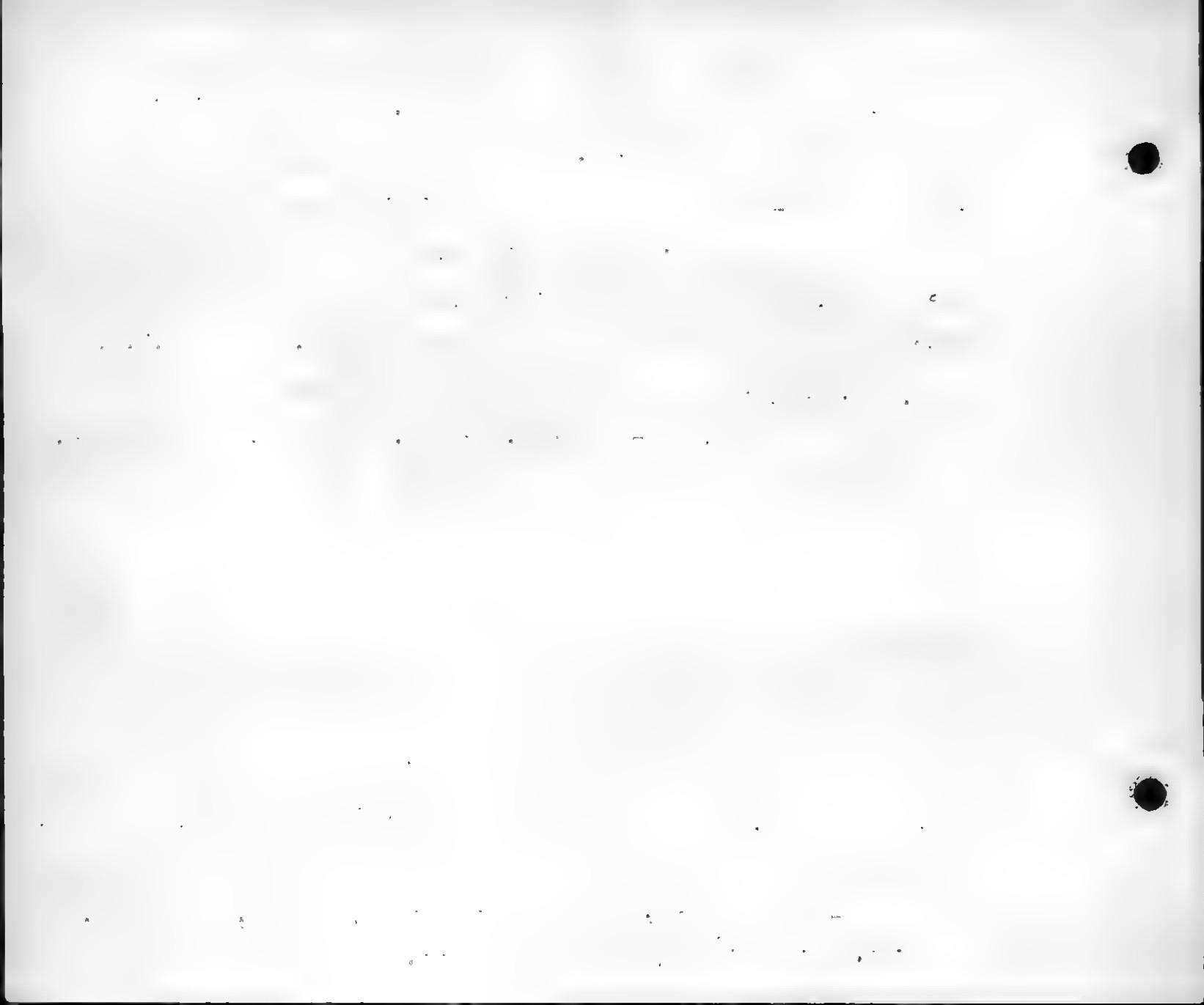
1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EIKTON		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELLA	Middle G. CROUCH	Last	4. DATE OF DEATH	Month 1-28-1960	Day 19	Year
5. SEX	6. COLOR OR RACE Female White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-1901	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Harry Arvants				14. MOTHER'S MAIDEN NAME Wilhemina Pennington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-32-2965		17. INFORMANT Laurence M.Crouch		Address North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis rt. post. inf. cerebrovascular</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 months 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from <i>3 Dec. 1957</i> , to <i>28 Jan. 1960</i> , that I last saw the deceased alive on <i>27 Jan. 1960</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Klaus H. Huebner</i> M.D. <i>Cecil Ave. North East, Md.</i> DATE SIGNED <i>29 Jan. 60</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-1960		22c. NAME OF CEMETERY OR CREMATORIUM North East Methodist		22d. LOCATION (City, town, or county) North East, Cecil Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i> Joseph R. Grant North East, Maryland				ADDRESS		24a. REC'D. BY REGISTRAR FEB 1 '60 DATE	24b. REGISTRAR'S SIGNATURE <i>Ervin S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician it completely fills in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR
 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00535			
CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY CECIL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Cecil								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 28 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			d. STREET ADDRESS 114 Landing Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital													
3. NAME OF DECEASED (Type or print)		First Paul	Middle E.	CRUIKSHANK XXXXXXXXX		4. DATE OF DEATH Jan. 17		Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1900		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Davis, West Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John E. Cruikshank						14. MOTHER'S MAIDEN NAME Stella Ketterman							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-3861		INFORMANT Mrs. Paul E. Cruikshank, Elkton, Md.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X DUE TO Carcinoma of stomach Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) N/A												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>Dec. 18</u> , 19 <u>59</u> to <u>Jan. 17</u> , 19 <u>60</u> . That I last saw the deceased alive on <u>Jan 17</u> , 19 <u>60</u> , and that death occurred at <u>Elkton</u> , Md., from the causes and on the date stated above. ACTUAL SIGNATURE: <u>Dr. Edward H. Lee Jr.</u> M.D.													
PHYSICIAN'S NAME (Type)		ADDRESS: <u>Elkton, Md.</u> DATE SIGNED: <u>Jan. 17-60</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-60		22c. NAME OF CEMETERY OR CREMATORIUM Immaculate Conception		22d. LOCATION (City, town, or county) Elkton		(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS <u>Donald H. Lee</u> <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR JAN 20 '60		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>							
VS A1S (4) 15-15													



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

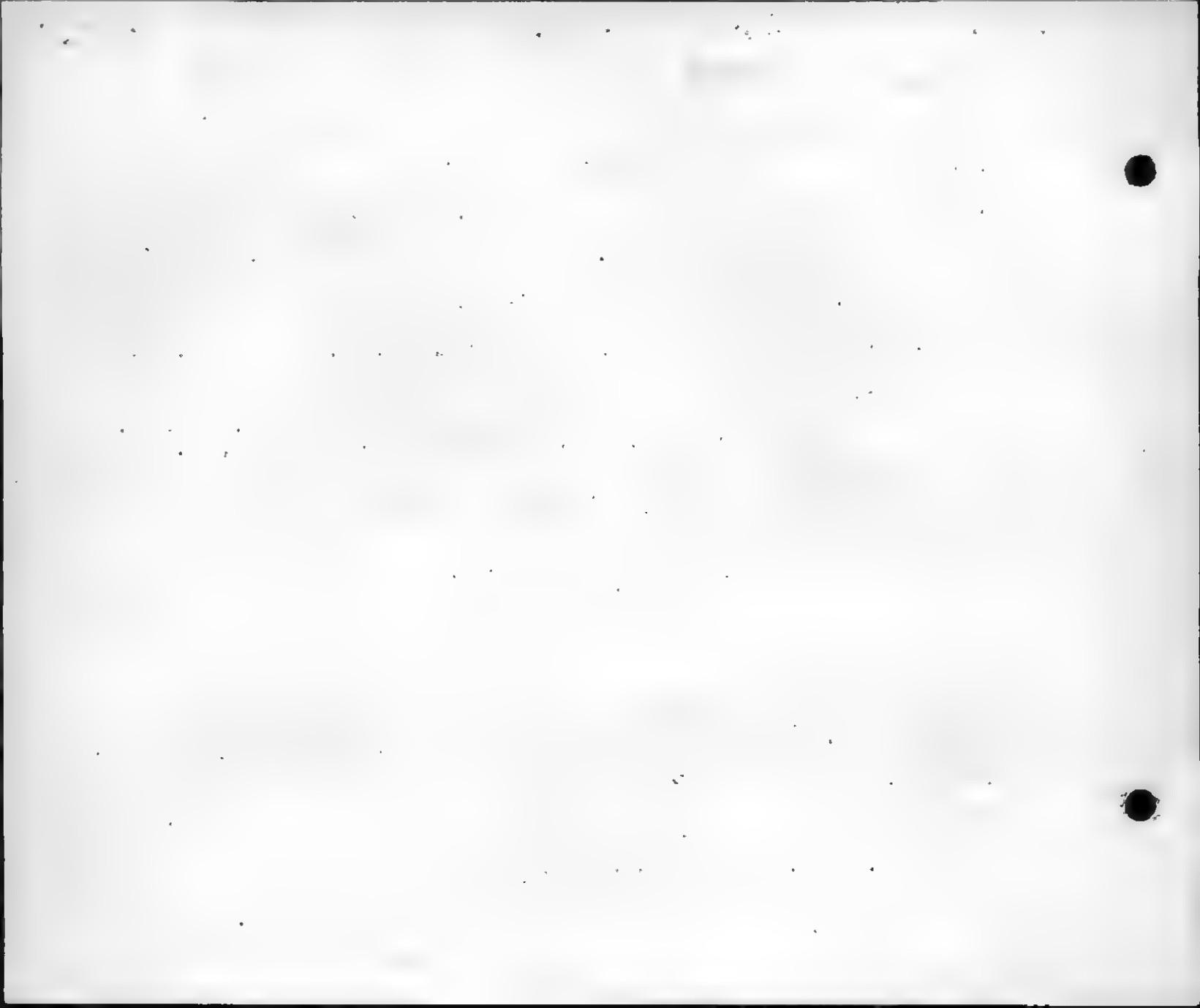
CERTIFICATE OF DEATH

Reg. Dist. No.

101537

**TO HOSPITAL OR
HOME:** The law requires that the death certificate be executed within 24 hours after death. Page 4
TO ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		0551		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,		c. LENGTH OF STAY IN 1b 2 yrs 7 mos 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 404 E. Joppa Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Henry	Middle C.	Last Eichhorn	4. DATE OF DEATH*	Month 1	Day 23	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-94	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not ascertainable		10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Eichhorn				14. MOTHER'S MAIDEN NAME Marcella Zinkhan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW II 216-05-3587		INFORMANT Elizabeth Eichhorn (W) Towson, Md.		404 E. Joppa Rd. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion							
DUE TO Rheumatic heart disease, inactive INTERVAL BETWEEN ONSET AND DEATH Immediate 3 yrs							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)							
DUE TO Subacute bacterial endocarditis in bacteria free state (c) 3 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-20 , 19 57 , to 1-23 , 19 60 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED 1-24-60							
ACTUAL SIGNATURE <i>Thomas P. Thompson</i>							
PHYSICIAN'S NAME (Type) Thomas P. Thompson, M.D.		M.D. VA Hospital, Perry Point, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 1-24-60		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Towson, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns Sons, Towson, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 29 '60		24b. REGISTRAR'S SIGNATURE <i>Carine L. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00538

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i>		c. LENGTH OF STAY IN 1b <i>80 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Maxey E Evans</i>		First <i>Maxey</i>	Middle <i>E</i>
		Last <i>Evans</i>	4. DATE OF DEATH <i>Jan 2 1960</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/17/1879</i>
9. AGE (In years last birthday) <i>80 yrs</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert E. Harrigan</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Carr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Thomas Evans Pleasant Hill</i>	
17. INFORMANT <i>Thomas Evans Pleasant Hill</i>		Address <i>Pleasant Hill</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 mth</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>260x</i> (b) DUE TO <i>Broncho Pneumia</i> (c) DUE TO <i>Diabetes & Urina</i>		INFERIOR <i>1 mth</i> 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12/26 1959</i> to <i>1/2 1960</i> that I last saw the deceased alive on <i>12/26 1959</i> and that death occurred at <i>9:45 AM</i> M, from the causes and on the date stated above.		ADDRESS (Street, city, or town, state) <i>205 W Main St</i>	
ACTUAL SIGNATURE <i>Joseph G Lanza M.D.</i>		DATE SIGNED <i>1/2 1960</i>	
PHYSICIAN'S NAME (Type) <i>Joseph G Lanza</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-5-1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Sharp's Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Fairfield Elton Rd Park Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph G Grant North East Md</i>		24a. REC'D BY REGISTRAR DATE JAN 5 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00533

053 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 307 Hollingsworth St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Perkins	Last Harvey
4. DATE OF DEATH	Month January	Day 23	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 1, 1884 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY General Devsp.	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Harvey		14. MOTHER'S MAIDEN NAME Eva Perkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Ethel Harvey, 307 Hollinsworth St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INFORMANT INTERVAL BETWEEN ONSET AND DEATH 10 days 3 years ? years?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/13, 1960, to 1/23, 1960, that I last saw the deceased alive on 1/22, 1960, and that death occurred at 5:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Peter Stavakis PHYSICIAN'S NAME (Type) PETER STAVAKIS M.D.		ADDRESS (Street, city or town, state) 154 W. Main Elkton, Md. DATE SIGNED 1/23/60	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/60	
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) Elkton, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Laph E. Hicks		24a. REC'D BY REGISTRAR FEB 1 '60	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE Charles L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



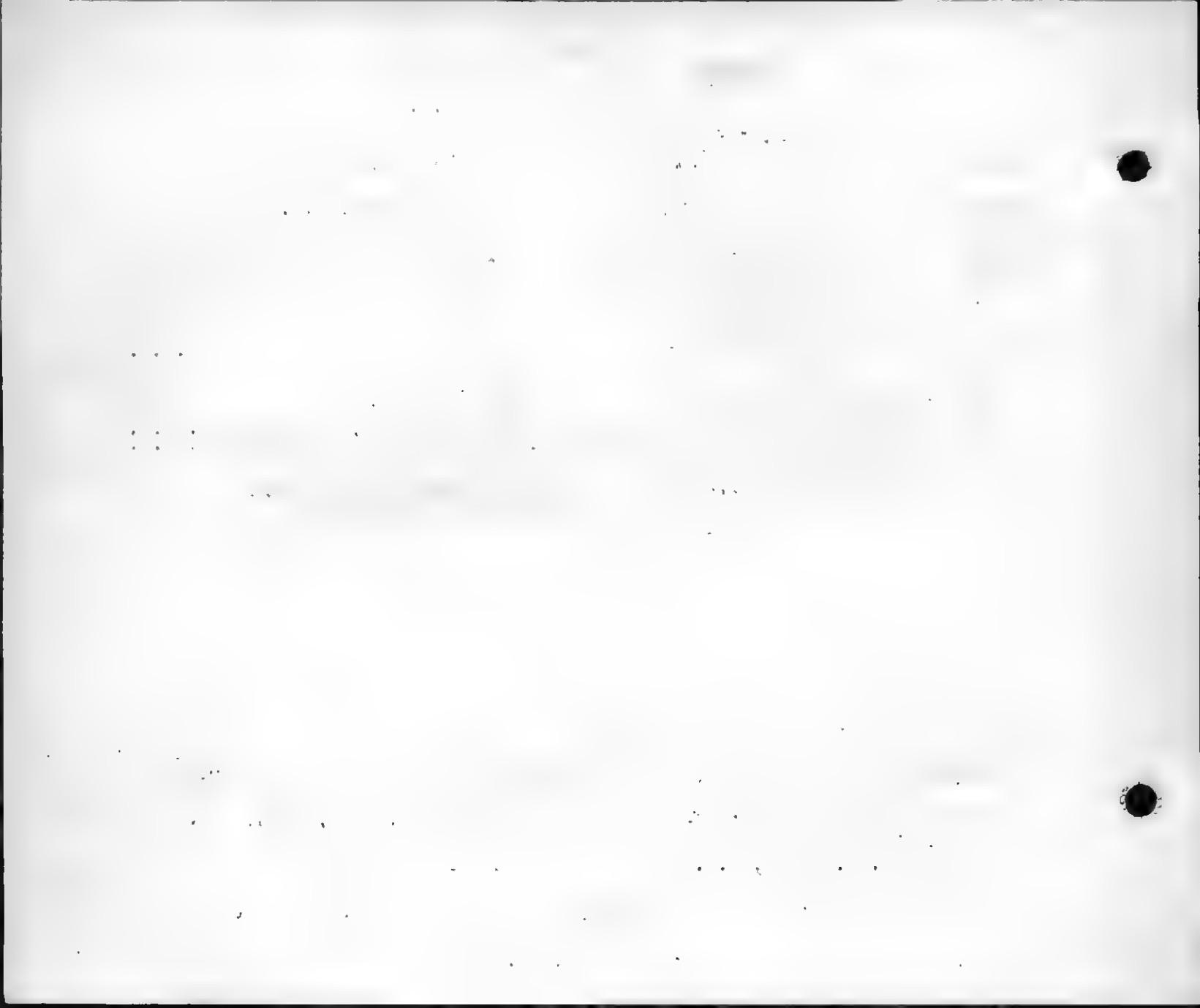
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00540

1		PLACE OF DEATH o. COUNTY Cecil	0552	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) d. STATE D.C. b. COUNTY		
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point	c. LENGTH OF STAY IN lb 6mos 17days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital	e. STREET ADDRESS 411 2nd Street, S.E.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		3. NAME OF DECEASED (Type or print) Cleveland	First (N.M.I.) Middle Hodge Last	4. DATE OF DEATH 1-18-11	Month 1 Day 30 Year 1960		
		5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-11	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	10b. KIND OF BUSINESS OR INDUSTRY Unknown	14. MOTHER'S MAIDEN NAME Jessie Burney			
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes	16. SOCIAL SECURITY NO. 578-03-7987	INFORMANT Mrs. Helen Wilson (S)		Address 411 2nd St. S.E. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Carcinoma of lungs with metastasis to bone, due to lymph nodes of chest cavity and abdominal lymph nodes				INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. MEDICAL CERTIFICATION		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that / attended the deceased from 7-13, 1959, to 1-30, 1960						ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>J. L. Garey</i>		M.D. VA Hosp. Perry Point, Md.				1-31-60	
PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.		Clinical Pathologist					
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 1-31-60		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) Ft. Myer, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Penningson & Son</i>		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Penningson	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

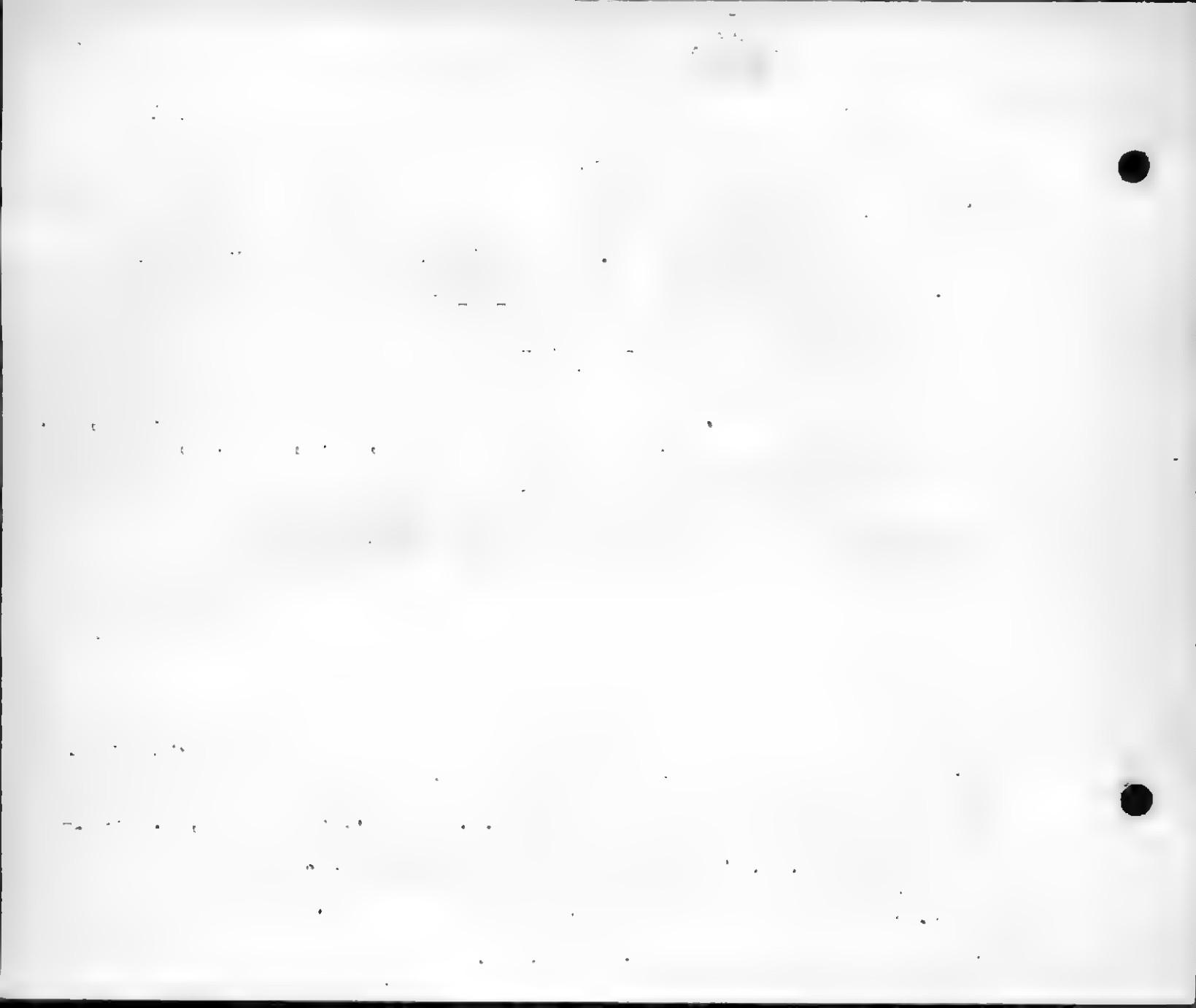
00541
96

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		d. STREET ADDRESS Route 1 Box 172A	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ALFRED	Middle J.	Last JACOBI	4. DATE OF DEATH January 19	Month January	Day 19	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-97	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advisor (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Patent - Government		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Jacobi (deceased)		14. MOTHER'S MAIDEN NAME Antonette Bonberg (deceased)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		INFORMANT Harriett Jacobi, wife, Route 1, Box 172A		Address Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 420.0							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized severe DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 9, 1960 , to January 19, 1960 and that death occurred at 8:50 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>J. L. Garey</i>		M.D. V.A. Hospital, Perry Point, Md. 1-21-60					
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist					
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/25/60		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE JAN 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00542

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		0554		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New York		b. COUNTY Essex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elton		c. LENGTH OF STAY IN 1b Enroute		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clintonville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 40		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Loretta	Middle La Mountain	Last	4. DATE OF DEATH Feb 24-1960	Month 1	Day 2	Year 1960	
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 24-1901	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hus wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Auscole Forks, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Martin Ryan		14. MOTHER'S MAIDEN NAME Katherine Karsce							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Michael Burke, Clintonville, N.Y.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture skull with loss of bone and brain tissue DUE TO Fracture right forearm and humerus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Crushed chest, Fracture left Tibia and Fibular and multiple bruises and abrasion over body DUE TO (c) Fractures on left thigh.									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit by car on Route 40							
20c. TIME OF INJURY Hour 6 p.m. 12 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) Elton		(County) Cecil	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>R.C. Dodson</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							DATE SIGNED 1-3-60
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF Jan 9, 1960		22c. NAME OF CEMETERY OR CREMATORIUM HOLY NAME CEMETERY		22d. LOCATION (City, town, or county) AUSABLE FORKS			(State) NEW YORK
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald A. Lee		ADDRESS Elton Md.		24a. REC'D BY REGISTRAR JAN 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause			



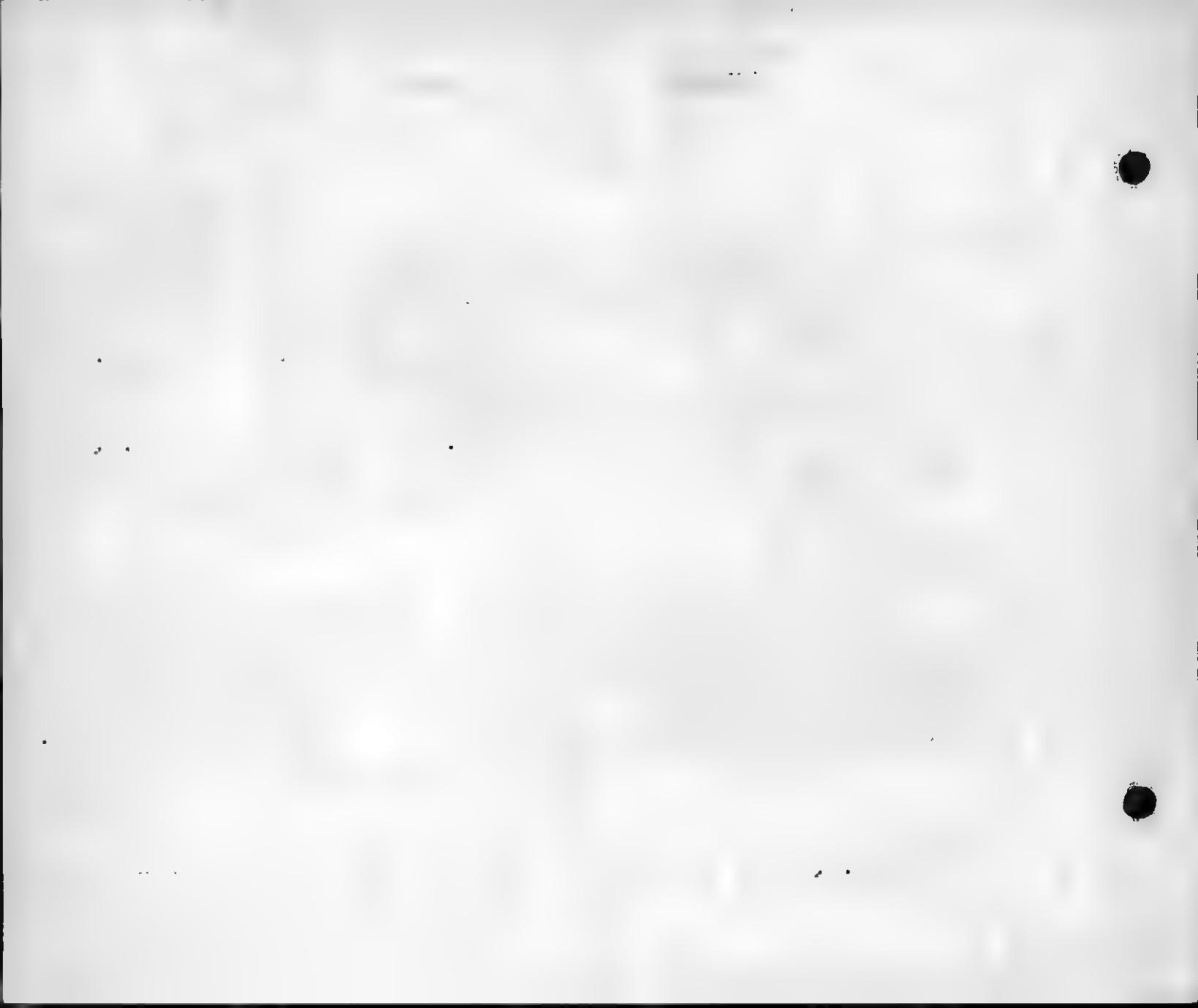
00543

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		0555		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Cecil		MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Elkton		Enr ute		Clintonville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
RTE # 40				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Raymond		Joseph	La Mountain		1 2 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-8-1902	57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Farmer		Farming		Clintonville, N.Y.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Joseph La Mountain		Elizabeth Tebo		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no				Mrs. E. Burke, Clintonville, N.Y.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fracture base of skull, Crushed right shoulder			
DUE TO		Crushed left side of cr. at 1 & 2 right eyebrow abrasion of face			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hit by automobile			
20c. TIME OF INJURY Month, Day, Year Hour a. m.		1 2 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
6:00			Route 40	Elkton	Cecil Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE		<i>R. C. Dodson</i>			
MATERIALS NAME (Type)		DATE SIGNED 1-3-60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)
REMOVAL		JAN 9, 1960	HOLY NAME CEMETERY		AUSABLE FORKS, NEW YORK
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	ELKTON	REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME Donald J. Lee		MD	DATE JAN 6 '60	Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00544

0539 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle LEWIS	4. DATE OF DEATH Month 1 Day 27 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 23 1886	9. AGE (In years less birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lewis		14. MOTHER'S MAIDEN NAME Mary Jane Roberts					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO [If yes, give war or date of service]		17. INFORMANT William R. Lewis		Address North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Cerebral Arterio Sclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) —	(County) —	(State) —	
21. I certify that I attended the deceased from <u>27 Jun</u> , 19 <u>60</u> , to <u>27 Jun</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>27 Jun</u> , 19 <u>60</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state). M.D. Cecil Ave. No. 44 Elkton, Md.		DATE SIGNED <u>27 Jun 62</u>	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Hines H. Hubbell M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-30-1960	22c. NAME OF CEMETERY OR CREMATORIUM Cherry Hill Methodist	22d. LOCATION (City, town, or county) Elkton Rural Cecil Co., Md	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph O. Grant		ADDRESS North East, Maryland	24a. REC'D BY REGISTRAR FEB 1 '60	24b. REGISTRAR'S SIGNATURE Cathleen S. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



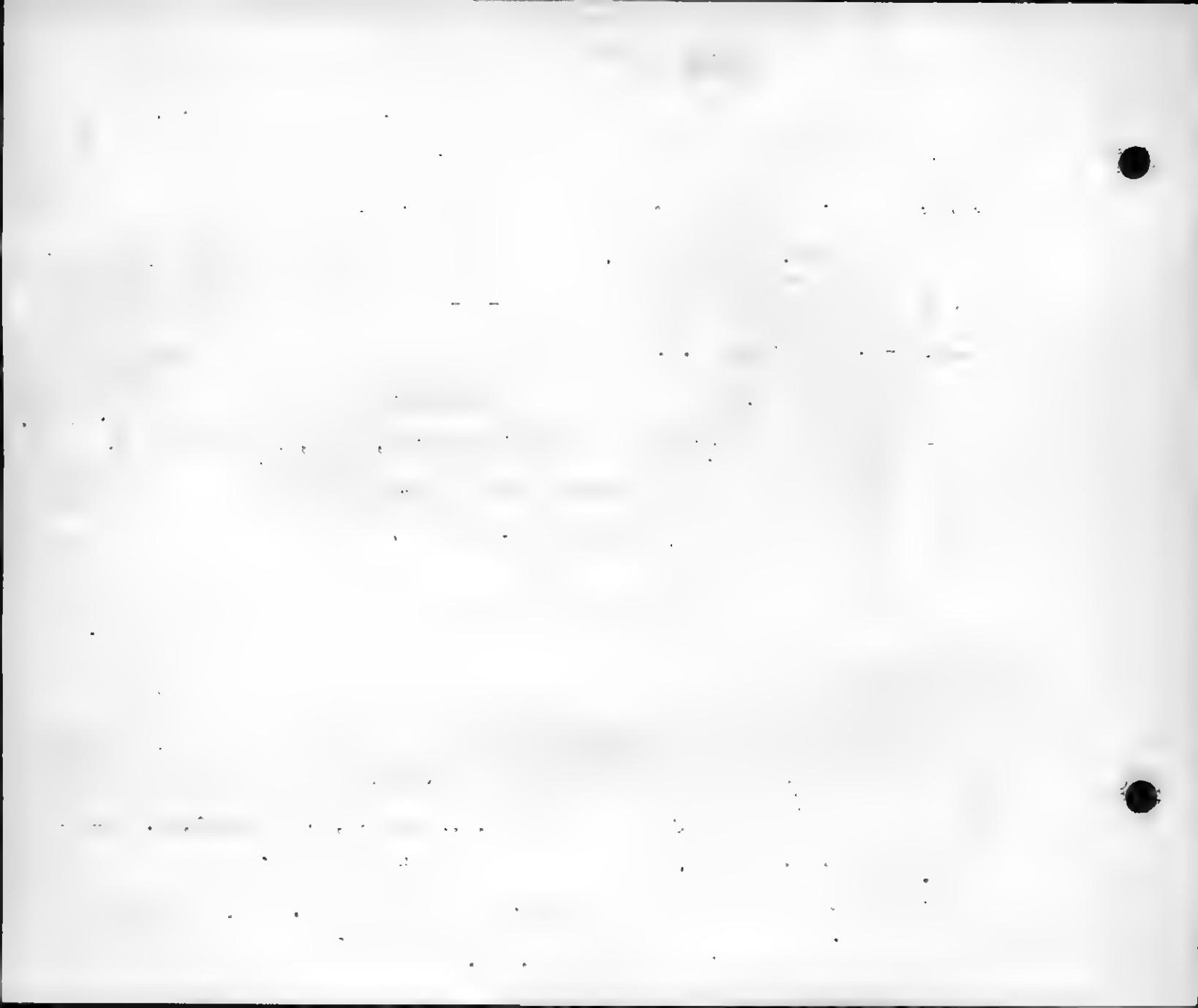
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00545

0556 CERTIFICATE OF DEATH

Reg. Dist. No. 96

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.					
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE							
Cecil		Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 hours							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point							
3. NAME OF (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
DR. STEPHAN		K.		MAYER	January	15	19	60	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-20-90	69 yrs.	Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician-Psychiatrist		10b. KIND OF BUSINESS OR INDUSTRY V.A. Hospital		11. BIRTHPLACE (State or foreign country) Germany		12 CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Otto Mayer		14. MOTHER'S MAIDEN NAME Anna Loewe							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Non-Veteran		16. SOCIAL SECURITY NO. Unknown		INFORMANT Cecilia Mayer, wife, 1139 Avenue B,		Address Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0		Arteriosclerotic heart disease				unknown			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Arteriosclerosis generalized severe				unknown			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
VA									
21. I certify that attended the deceased from January 14, 1960, to January 15, 1960.		and that death occurred at 12:15 AM from the causes and on the date stated above.				ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE J. L. Garey						DATE SIGNED 1-15-60			
PHYSICIAN'S NAME (Type) J. L. GAREY		M.D. V.A. Hospital, Perry Point, Md.				Clinical Pathologist			
22a. BURIAL/CREMATION REMOVAL (Specify)		22b. DATE THEREOF 1/16/60	22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Crematory Baltimore, Maryland		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR JAN 18 1960		24b. REGISTRAR'S SIGNATURE Cecilia Mayer			
VS AIS (4) 1SM 9/58									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00546

CERTIFICATE OF DEATH

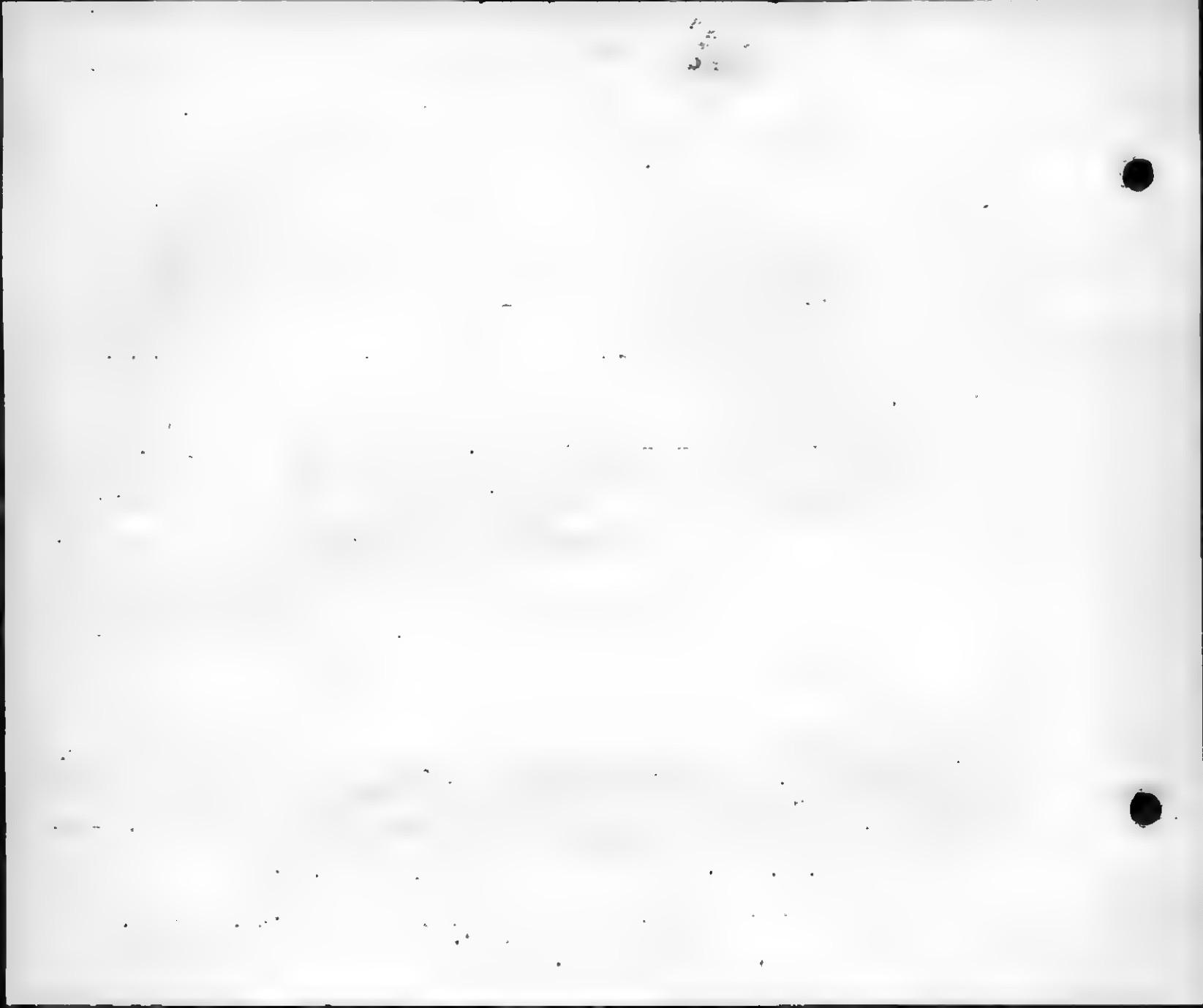
Reg. Dist. No.

96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,		c. LENGTH OF STAY IN 1b 1 mo. 14 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 1517-2				
3. NAME OF DECEASED (Type or print) John		First Middle Thomas	4. DATE OF DEATH Norton 1	Month 24	Day 19	Year 60
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 9-16-1903	9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Not ascertainable		11. BIRTHPLACE (State or foreign country) Aspen, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert L. Norton		14. MOTHER'S MAIDEN NAME Marion E. Norton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 212-14-8787	INFORMANT Robert L. Norton (B)	6410 4th Avenue Takoma Park, Md.		
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		Hemorrhage sub-dural, right		INTERVAL BETWEEN ONSET AND DEATH 48-96 hours		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first		(b) Arteriosclerosis cerebral severe		unknown		
DUE TO		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Arteriosclerosis generalized severe		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that / attended the deceased from 12-10, 19 59, to 1-24, 19 60		and that death occurred at 6:30PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>J. L. Garey</i>		M.D.		DATE SIGNED		
PHYSICIAN'S NAME (Type) J. L. GAREY		VA Hospital, Perry Point, Md. 1-25-60		Clinical Pathologist		
22a. BURIAL, CREMATION REMOVAL (Specify) Burial Jan. 28, 1960		22b. DATE THEREOF Jan. 28, 1960	22c. NAME OF CEMETERY OR CREMATORIAL George Washington Memorial	22d. LOCATION (City, town, or county) Adelphi, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Takoma Funeral Home, 254 Carroll St. Takoma		ADDRESS Park, Md.	24a. REC'D BY REGISTRAR DATE JAN 27 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00547

0546

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institutional, Residence before admission] a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)		c. LENGTH OF STAY IN 1b 35 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine		Middle Novotny	Last	4. DATE OF DEATH Jan. 5	Month Jan.	Day 5	Year 60 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 22, 1875	C. AGE (In years last birthday) 84 yrs.	D. IF UNDER 1 YEAR Months Days	E. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Bohemia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vaclav Kovarnik			14. MOTHER'S MAIDEN NAME No information				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. no		17. INFORMANT Joseph Novotny		Address North East, R.D., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Hypertensive Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric Ulcer							
INTERVAL BETWEEN ONSET AND DEATH 4 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) — — —	
21. I certify that I attended the deceased from 1 Jan., 1960, to 5 Jan., 1960, that I last saw the deceased alive on 5 Jan., 1960, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Klaus H. Heubner M.D. North East, Md. DATE SIGNED 1/8/60 PHYSICIAN'S NAME (Type) Klaus H. Heubner G.I.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-60		22c. NAME OF CEMETERY OR CREMATORIUM North East Methodist		22d. LOCATION (City, town, or county) Cem. North East Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR JAN 11 '60		24b. REGISTRAR'S SIGNATURE C. J. S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0559 CERTIFICATE OF DEATH

Reg. Dist. No. 96

00548
96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 34 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS 4407 Penhurst Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST TLTON Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HENRY	Middle S.	Last POPP	4. DATE OF DEATH 4-25-91	Month 1	Day 29	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-91	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not Available From Records				14. MOTHER'S MAIDEN NAME Not Available From Records			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1		INFORMANT Mrs. A. J. Plantholt		4407 Penhurst Avenue Baltimore, Md. (Sister)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved INTERVAL BETWEEN ONSET AND DEATH 3-4 Days 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. VA		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) VA	(County) VA	(State) VA
21. I certify that I attended the deceased from 6-27- to 1-29- 19 25 , to 1-29- 19 60 , and that death occurred at 10:25 AM from the causes and on the date stated above ACTUAL SIGNATURE Lab Kajdi ADDRESS (Street, city or town, state) VA HOSPITAL, PERRY POINT, MARYLAND DATE SIGNED 1/29/60							
PHYSICIAN'S NAME (Type) LASLO KAJDI, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Feb 29/1960 22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer 22d. LOCATION (City, town, or county) Baltimore (State) MD					
23. FUNERAL DIRECTOR'S SIGNATURE Henry Arment		ADDRESS 4204 Ridgemoor Dr.		24a. REC'D BY REGISTRAR Feb 1 '60	24b. REGISTRAR'S SIGNATURE Charles S. Kline		

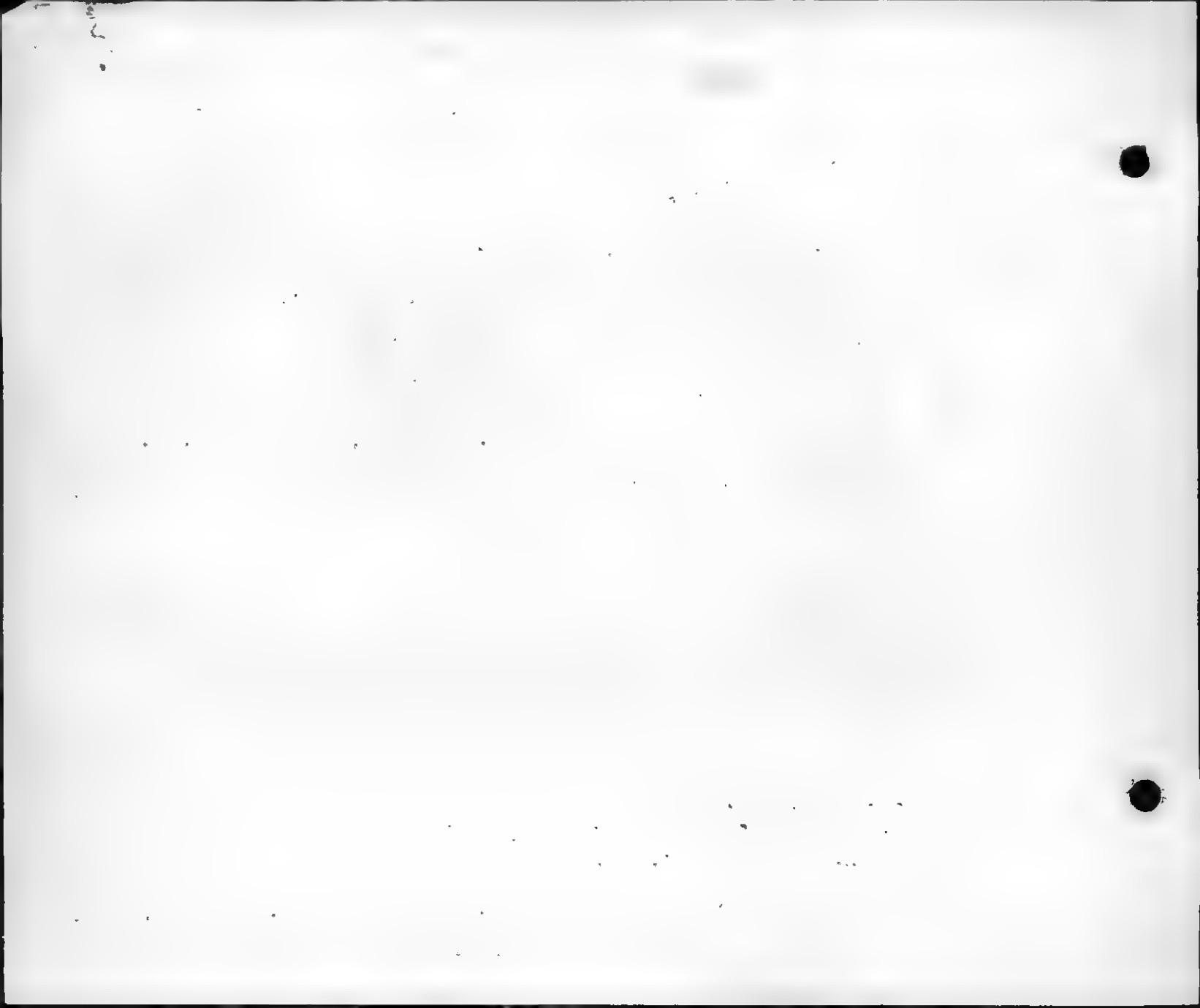


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00540

1. PLACE OF DEATH a. COUNTY		0560 Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Perryville, Rural 4 yrs		d. STATE Maryland b. COUNTY Cecil	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Aikin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rising Sun	
3. NAME OF DECEASED (Type or print)		First Henry	Middle S.	4. DATE OF DEATH Price	Month January Day 9 Year 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1870	9. AGE (In years from birthday) 89 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Own Shop		11 BIRTHPLACE (State or foreign country) Maryland	
13 FATHER'S NAME Vachel Price		14. MOTHER'S MAIDEN NAME Millicent Simpers		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		INFORMANT Address Mrs. W.B.Thomas, Perryville, Md.Rural	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cambro-Vesco - Accident</i> 432.2.2 DUE TO <i>Myocarditis</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 5, 1958</i> , to <i>Jan 5, 1960</i> , that I last saw the deceased alive on <i>Jan 8, 1960</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>G.H. Richards Jr., M.D.</i>		ADDRESS (Street, city or town, state) <i>Bethel Baptist, Rd 1-8-6</i>		DATE SIGNED <i>Feb 1960</i>	
PHYSICIAN'S NAME (Type) G.H. Richards Jr., M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-1960		22c. NAME OF CEMETERY OR CREMATORIUM Rose Bank Cemetery	
22d. LOCATION (City, town, or county) (State) Calvert, Cecil Co., Md.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leva Patterson, Jr.</i>		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE JAN 12 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knott</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0528

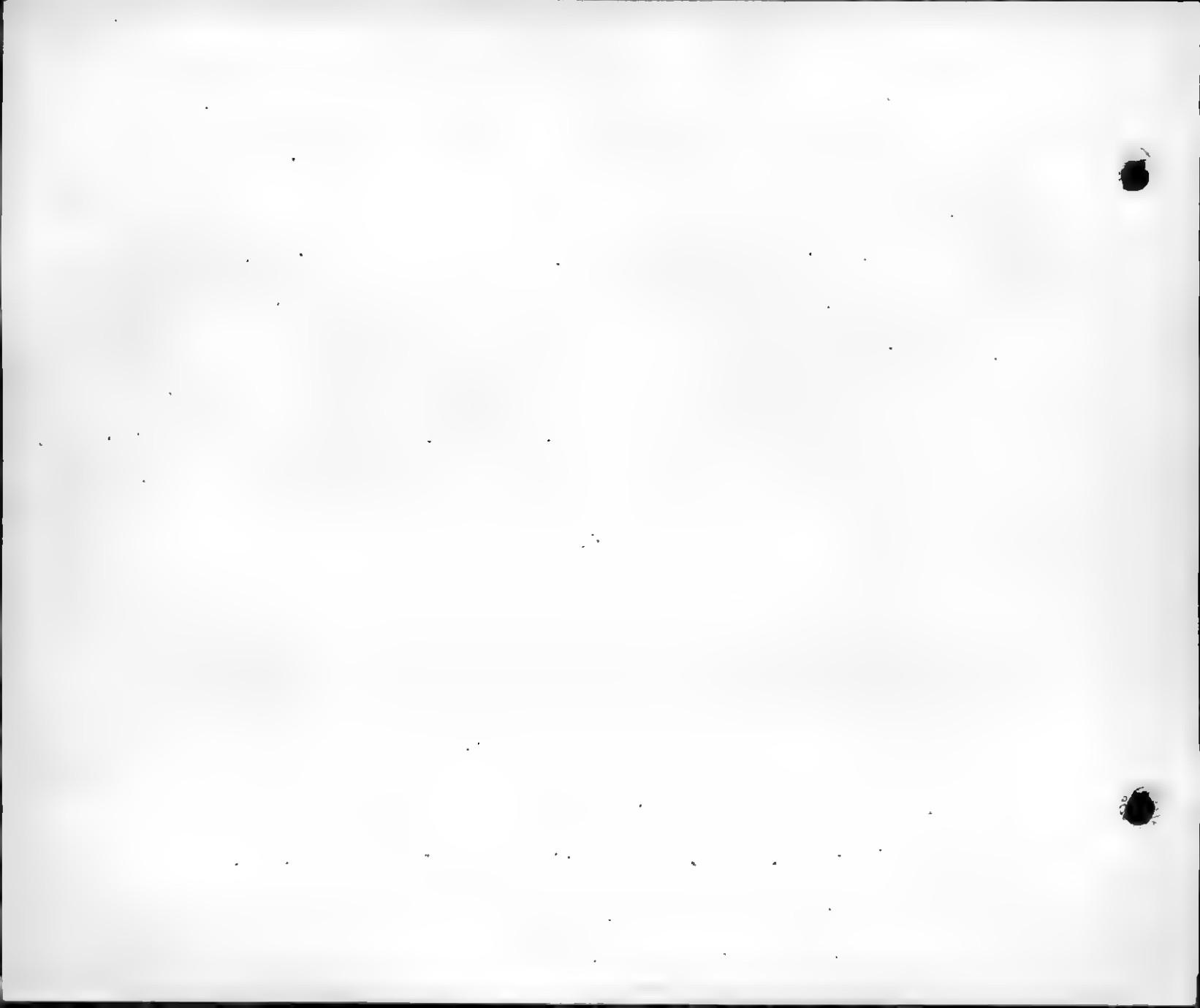
CERTIFICATE OF DEATH

Reg. Dist. No.

00550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE CITY		c. LENGTH OF STAY IN 1b 7 WEEKS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MORGAN NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle M.	Last REED JR.
4. DATE OF DEATH	Month JANUARY	Day 10	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 2, 1876
9. AGE (In years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 83	11. IF UNDER 24 HRS Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN M. REED	14. MOTHER'S MAIDEN NAME EMILY S. SMITHERS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	INFORMANT HELEN H. REED	Address CHES. CITY MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CHRONIC CARDIO-VASCULAR RENAL DISEASE DUE TO (b) 2 yrs (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 10, 1960 , to Jan 10, 1960 , that I last saw the deceased alive on Jan 10, 1960 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE HENRY V. DAVIS	M.D.		
PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD	CHESAPEAKE CITY MD		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN 13, 1960	22c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY	22d. LOCATION (City, town, or county) CHESAPEAKE CITY Md.
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald H. Lee	ADDRESS ELKTON, Md.	24a. REC'D BY REGISTRAR DATE JAN 15 '60	24b. REGISTRAR'S SIGNATURE Carroll S. Thomas



00551

0534

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY CECIL MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY CECIL					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON 6 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ELKTON					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSR.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First EMILY	Middle E.	Last Reeves	4. DATE OF DEATH JAN.	Month	Day	Year 1960
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 23, 1927	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) ELKTON, MD	12. CITIZEN OF WHAT COUNTRY? USA,			
13. FATHER'S NAME EMEL CEBULA 14. MOTHER'S MAIDEN NAME ESTHER VANDERGRIFT								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 216-22-4215	INFORMANT WILEY H. REEVES	Address ELKTON, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 DUE TO Massive Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 3 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO Acute Myeloid Leukemia 6 wks. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 2 Jan., 1960, to 8 Jan., 1960, that I last saw the deceased alive on 8 Jan., 1960, and that death occurred at Elkton, MD, from the causes and on the date stated above. ACTUAL SIGNATURE George J. Kreis Jr. M.D. ADDRESS (Street, city or town, state) Elkton, MD DATE SIGNED 11/8/60 PHYSICIAN'S NAME (Type) GEORGE J. KREIS JR.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL JAN. 12, 1960		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM UNION CEMETERY		22d. LOCATION (City, town, or county) (State) UNION, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Lowell M. Lee		ADDRESS ELKTON MD.		24a. REC'D BY REGISTRAR JAN 15 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Thomas		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.
 FURNISH INFORMATION: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00552		
0540 CERTIFICATE OF DEATH										Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN lb 23 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			d. STREET ADDRESS Devine Nursing Home				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home											e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Irvin		Middle S. Reynolds		Last		4. DATE OF DEATH		Month	Day	Year
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Male White WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) 68 yrs		IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Basket Maker & Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North East, Maryland						12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Sylvester S. Reynolds					14. MOTHER'S MAIDEN NAME Katherine Grant							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		Address Mrs Edith Goodnow Reynolds North East Md						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 4. DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH (3) days unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from Dec. 29, 1959 , to Jan 20, 1960 , that I last saw the deceased alive on Jan. 20, 1960 , and that death occurred at 7:55a M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 2339 E. Main Street M.D.										
ACTUAL SIGNATURE 		DATE SIGNED 1/20/60										
PHYSICIAN'S NAME (Type)		S. RALPH ANDREWS, JR., M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)				
Burial		1-23-1960		North East Methodist		North East, Cecil Co., Md						
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grace		ADDRESS				24a. REC'D BY REGISTRAR JAN 25 '60		24b. REGISTRAR'S SIGNATURE Irvin S. Thomas				
VS A15 (4) 1SM 9/5B												



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Form 5-24-50 et

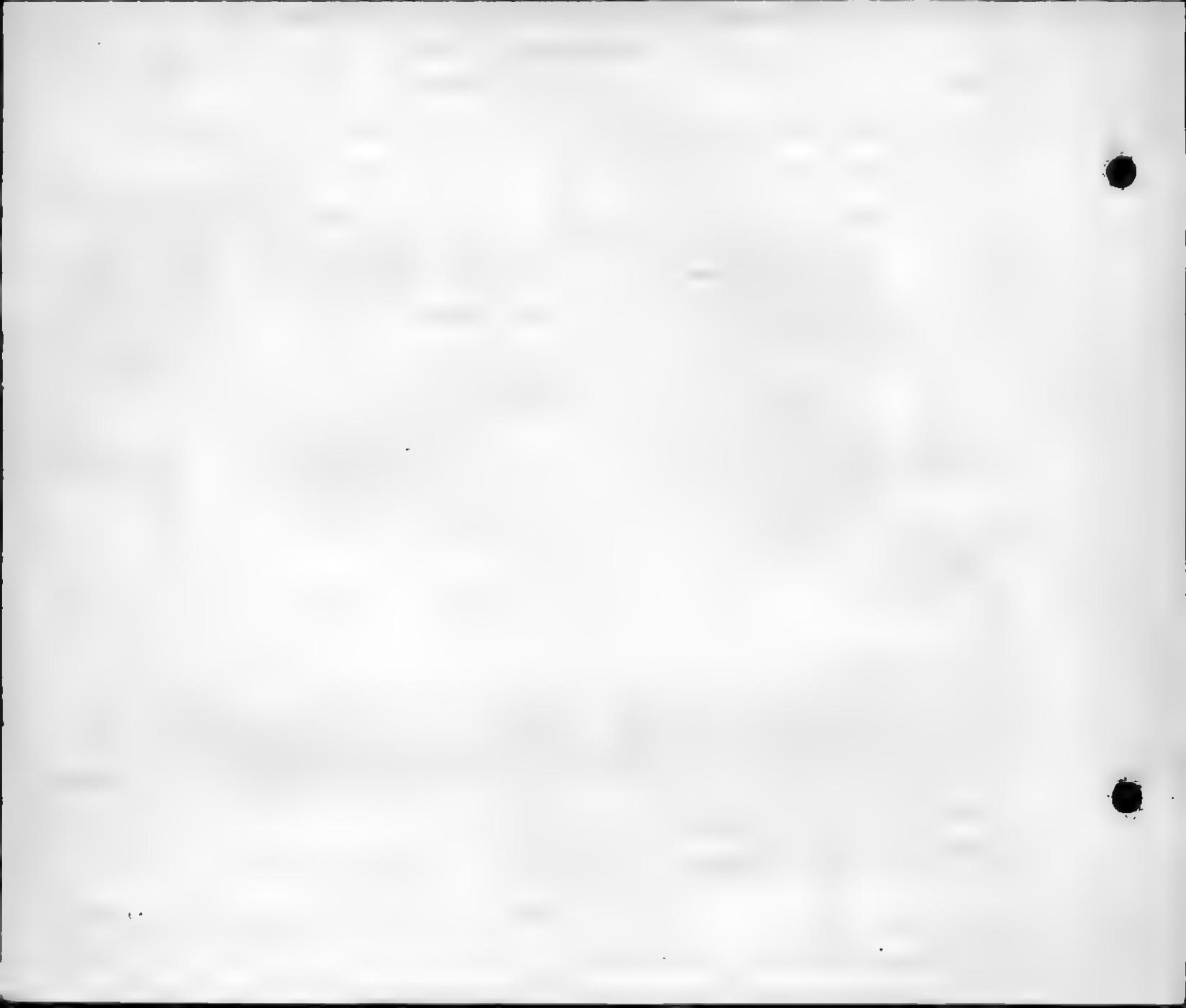
00553

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE [Where deceased lived if institution; Residence before admission] a. STATE MARYLAND	
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] Elkton		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL [If not in hospital, give street address] OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestowm	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDITH		4. DATE OF DEATH Month 1 Day 29 Year 1960	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 5 1892	
9. AGE (In years last birthday) 67 68 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
10c. BIRTHPLACE (State or foreign country) Maryland		10d. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David J. Johnson		14. MOTHER'S MAIDEN NAME Amanda E. Samuels	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Ellen		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Cardiac C (c) 3 Years INTERVAL BETWEEN ONSET AND DEATH 1 day 3 Years 3 Years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] 12/3/1958	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 245 S. High St., Elkton, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/3/1958 , to 1/29/1960 , that I last saw the deceased alive on 12/28/1958 , and that death occurred at 1A , M, from the causes and on the date stated above. ACTUAL SIGNATURE James L. Johnson PHYSICIAN'S NAME (Type) James L. Johnson		ADDRESS (Street, city or town, state) 113/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-1960	
22c. NAME OF CEMETERY OR CREMATORIUM Trinity Methodist		22d. LOCATION (City, town, or county) (State) Zion Rural Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR FEB 1 '60	
ADDRESS North East, Maryland		24b. REGISTRAR'S SIGNATURE Conrad S. Trahan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

055

CERTIFICATE OF DEATH

Reg. Dist. No. 00553

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecil</i>	c. LENGTH OF STAY IN 1b -	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North East</i>	d. STREET ADDRESS d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>	e. FIRST MIDDLE LAST <i>BABY BOY SHOCKLEY</i>	f. DATE OF DEATH Month Day Year <i>1 23 1960</i>					
3. NAME OF DECEASED (Type or print)	4. COLOR OR RACE <i>W</i>	5. SEX <i>M</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH <i>1-23-1960</i>	8. AGE (In years last birthday) yrs. <i>8</i>	9. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>	10. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Russell William Shockley</i>		14. MOTHER'S MAIDEN NAME <i>Rose Marie Ball</i>		Address <i>Ros. Marie Shockley North East Md</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Ros. Marie Shockley</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>Maternal Anemia - premature rupture of membranes and partial decapitate separation at presentation</i> INTERVAL BETWEEN ONSET AND DEATH <i>8/4/17</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from <i>23 Jan.</i> , 19 <i>60</i> , to <i>23 Jan.</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>23 Jan.</i> , 19 <i>60</i> , and that death occurred at <i>613 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>North East Md</i>		DATE SIGNED <i>1/23/60</i>			
ACTUAL SIGNATURE <i>Hlaus H. Hueston</i>		PHYSICIAN'S NAME (Type) <i>Hlaus H. Hueston Jr.D</i>		22d. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		22e. DATE THEREOF <i>1-20-1960</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS <i>North East Md</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>North East Cemetery</i>		22d. LOCATION (City, town, or county) <i>North East Cecil Md</i>	
				24a. REC'D BY REGISTRAR DATE JAN 27 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

101555

Reg. Dist. No.

FOR STATE
HEALTH DEPT.
18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, who should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for filing.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		0543		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)				
Cecil						b. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. COUNTY Cecil						
Elkton		20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				Elkton						
7 Collins Court				d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print)		First	Middle	lost	4. DATE OF DEATH	Month	Day	Year		
Levi		M	Shockley		1	29	19	60		
5. SEX		6 COLOR OR RACE	7 MARRIED	NEVER MARRIED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
M		C	WIDOWED	DIVORCED	9-25-1889	70 yrs	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Laborer				Fruitland, Md.		U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
John Shockley		Mary Shockley								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
Yes W.H.1		717-07-5346		Rev. Shockley, Wilmington, Del.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Acute Coronary Occlusion								
420.1										
DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Angine for several years						
DUE TO										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
19										
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>R.C. Dodson</i>						DATE SIGNED 1-29-60				
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL/CREMATION/REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/60		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive Cem.		22d. LOCATION (City, town, or county) Fruitland, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edu. R. Bell</i>		ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR FEB 2 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				
VS. A15ME 5M 2/57										

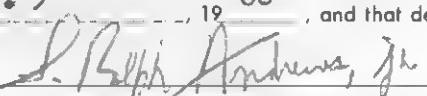


TO HOSPITAL OR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00556

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON	
3. NAME OF DECEASED (Type or print) ALICE		First L.	Middle SINGLETON
		Last SINGLETON	4. DATE OF DEATH JANUARY 9, 1960
S. SEX F	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2, 1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME HENRY GREEN		14. MOTHER'S MAIDEN NAME BERTHA BIDDLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	INFORMANT WILLIAM W. SINGLETON
			Address ELKTON, MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420/1 DUE TO. Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1959 to Jan. 9, 1960 , that I last saw the deceased alive on Jan. 9, 1960 , and that death occurred at 6:20a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE 		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 1/9/60	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D.		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 12, 1960	22c. NAME OF CEMETERY OR CREMATORIAL PARK GILPIN MANOR MEM. PARK
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Donald M. Rue	24a. REC'D BY REGISTRAR DATE JAN 15 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



00558

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

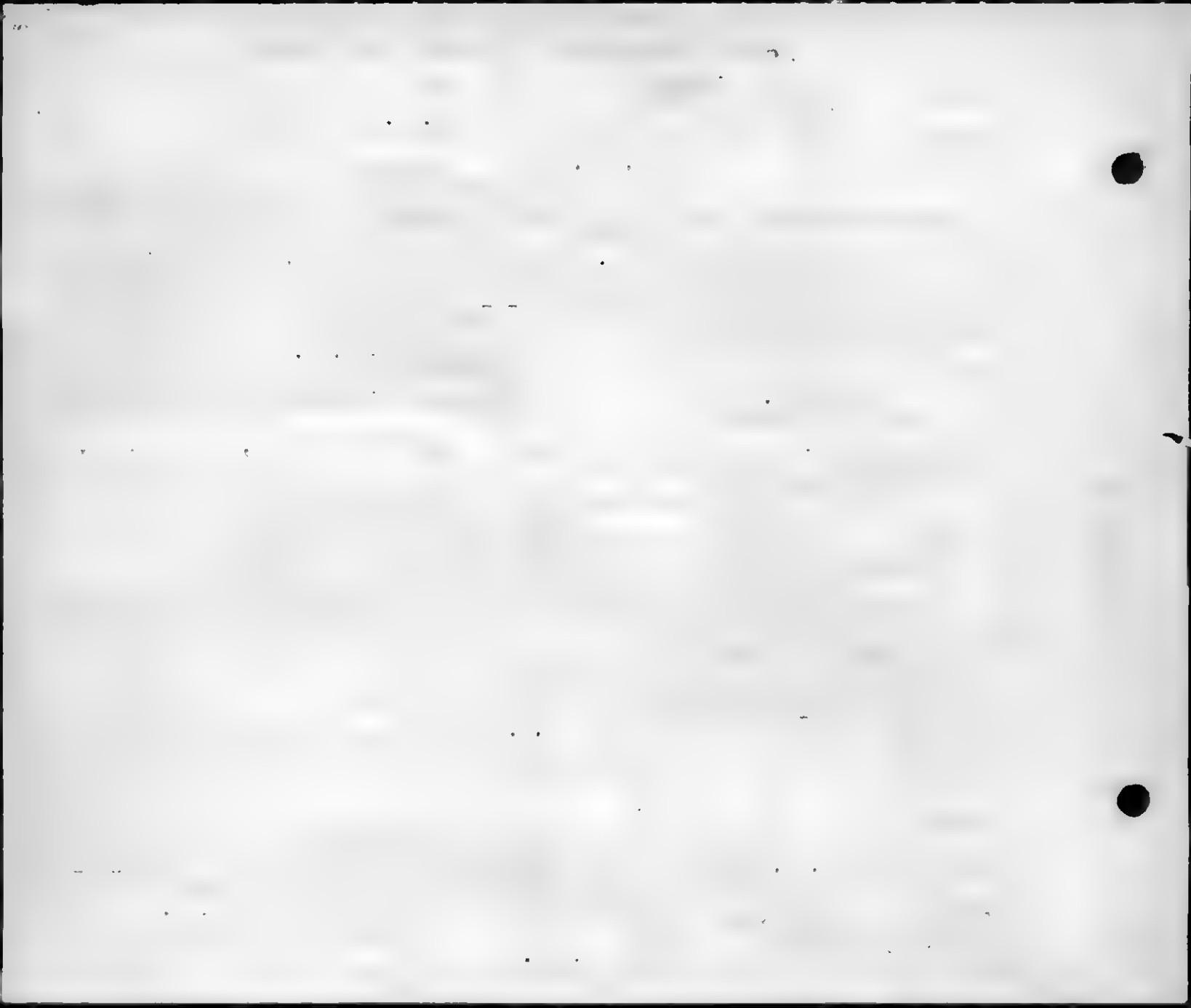
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY		0561		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Cecil		MARYLAND		d. STATE D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY	
Perry Point		26 yrs. 7 mo. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Veterans Administration Hospital		Washington		Northumberland	
47 X -					
3. NAME OF DECEASED (Type or print)		First EDGAR	Middle D.	Last SMITH	4. DATE OF DEATH January 27 1960
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 7-2-98	
9. AGE (in years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA		10b. KIND OF BUSINESS OR INDUSTRY Government			
13. FATHER'S NAME James E. Smith		14. MOTHER'S MAIDEN NAME Emma McNeir		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Margaret Groves (S) Box 84, Charmian, Pa.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by food</u> DUE TO <u>9217</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Food found in Bronchi</u> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. 7:40 1-27-60		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) V.A. Hospital Perry Point, Maryland	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R. C. Dodson</i>		DATE SIGNED 1-27-60			
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/60		22c. NAME OF CEMETERY OR CREMATORIUM Congressional	
22d. LOCATION (City, town, or county) Washington, D. C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Grove</i>		ADDRESS Walter Grove Fun. Home, Waynesboro, Pa.		24a. REC'D BY REGISTRAR JAN 29 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55



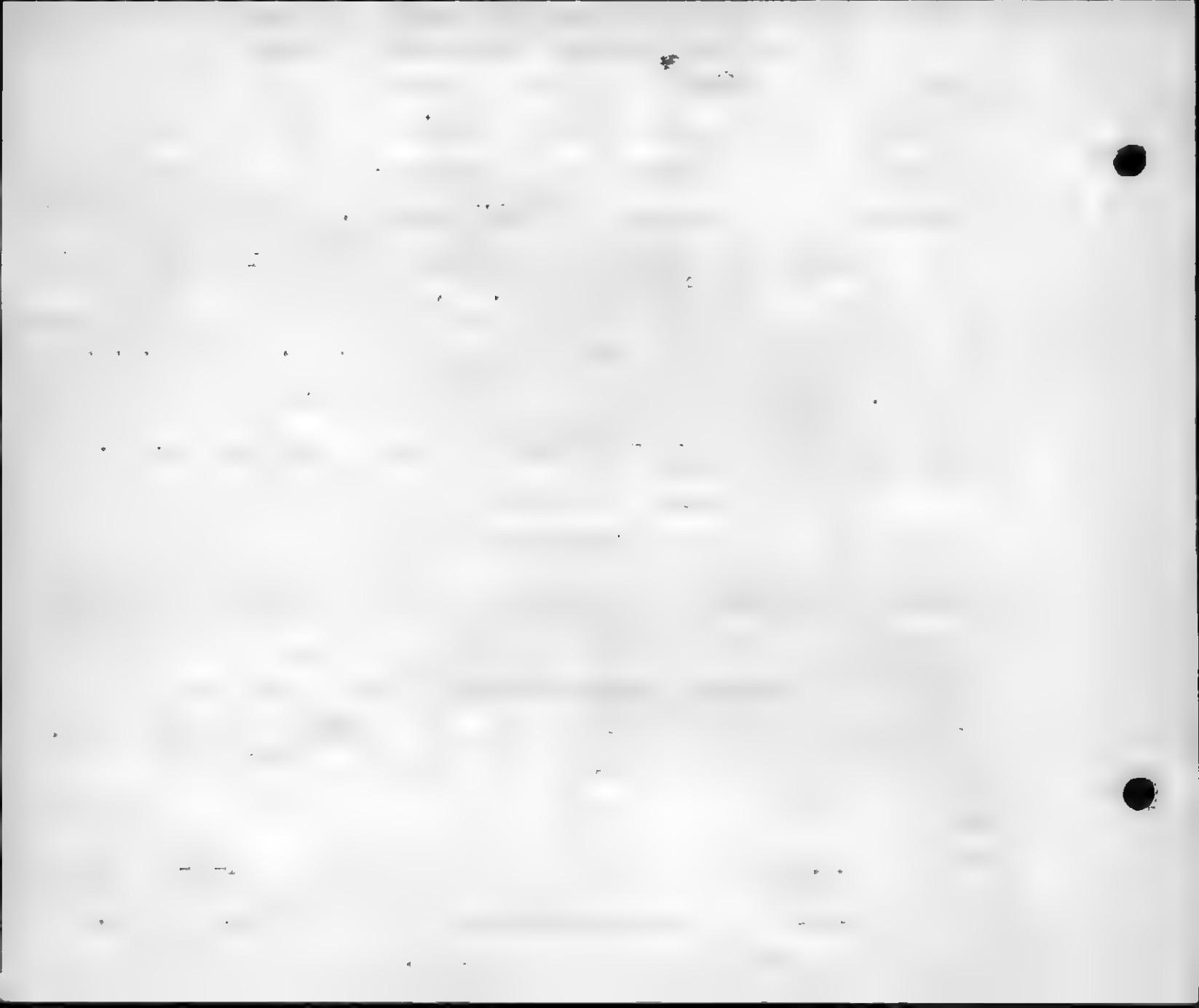
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00558

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		0557		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
Cecil		MARYLAND		a. STATE Md.	b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Elkton		enroute		Chestertown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
Route 40				113 Maple Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year		
George		William		Spencer	1 23 1960		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1938	9. AGE (In years last birthday) 22 yrs.		
M		W			IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
Laborer		Vita Food		Philadelphia, Pa.			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
				Joseph P. Piazza			
14. MOTHER'S MAIDEN NAME				Thelma Kennard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT			
		220-32-1859		Mrs. Eva Long			
				Address Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fracture of Base of skull and					
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		DUE TO Fractured neck					
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Hit another car while driving in wrong lane					
20c. TIME OF INJURY Hour 6-35 p.m.		Month, Day, Year 1 23 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40	20f. (City or town) Elkton	(County) Cecil	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R.C. Dodson</i>		DATE SIGNED 1-21-60					
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-60		22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		22d. LOCATION (City, town, or county) Chestertown	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS <i>Elkton, Md.</i>		24a. REC'D BY REGISTRAR Mar. 27 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

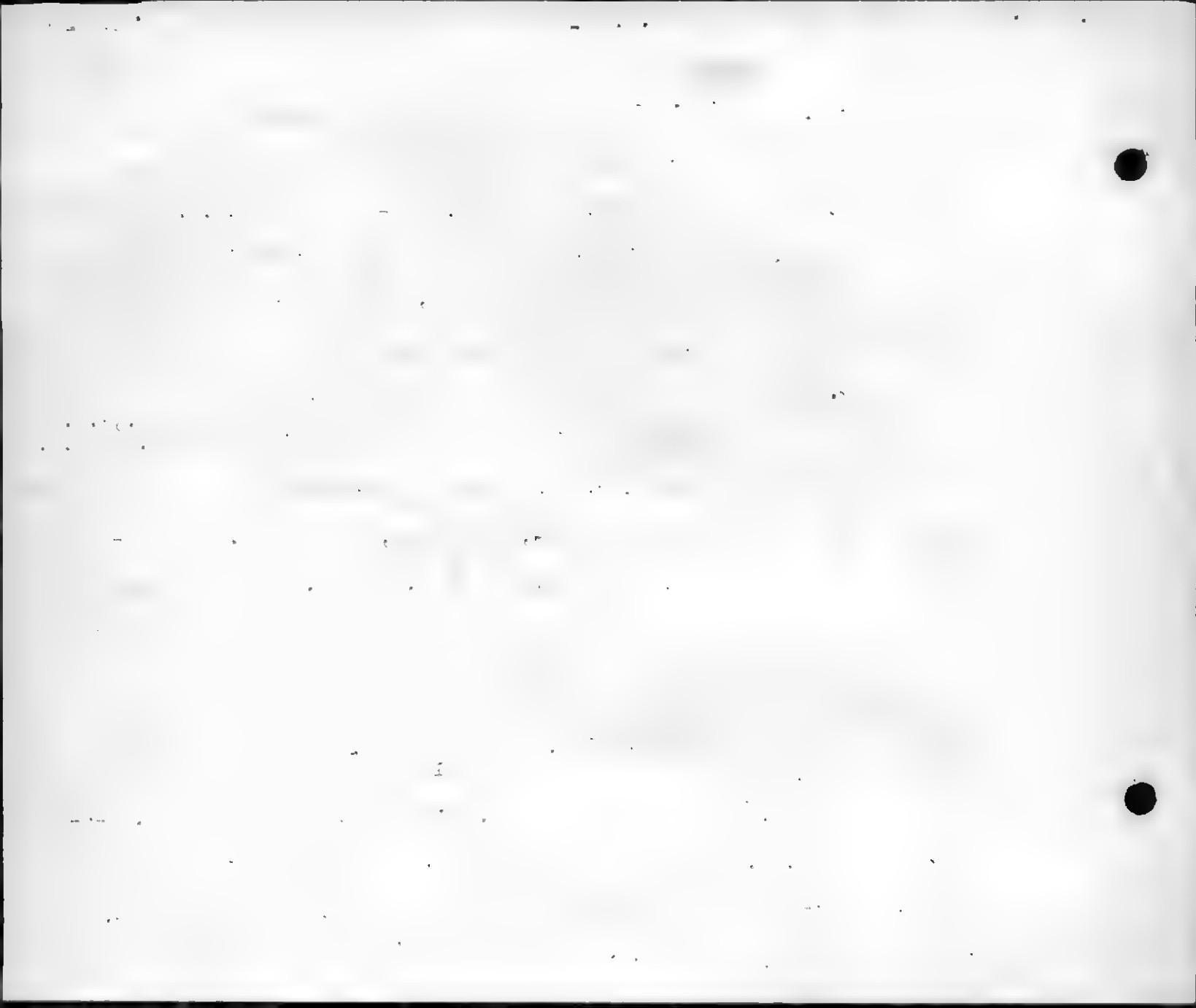
011553

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Cecil		0562		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 yrs 9 mos 3 days		b. COUNTY Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1741 - 8th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)	First EDDIE	Middle (NMI)	Last STOKES	4. DATE OF DEATH January	Month 7	Day Year 1960
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1896	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS Hours 12
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Stokes			14. MOTHER'S MAIDEN NAME Janie Coleman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		INFORMANT Cordelia Stokes, Daughter, 451 M St., N.W., Washington, D.C.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Azotemia, uremic poisoning (clinical) INTERVAL BETWEEN ONSET AND DEATH 4 - 5 weeks						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 446 X		DUE TO (b) Bronchopneumonia, left lung, unresolved.		5 - 6 days		
DUE TO (c) Nephrosclerosis, bilateral, severe.					Unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 4, 1957 to January 7, 1960 and that death occurred at 1:00 AM from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>J. L. Garey</i> ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. 1-8-60 DATE SIGNED						
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist				
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 1-8-60	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>PENNINGTON & SON, Inc.</i>		ADDRESS Havre DeGrace, Md.		24a. REC'D BY REGISTRAR DATE JAN 12 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	0563		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
Cecil	MARYLAND		a. STATE Maryland b. COUNTY Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Ferry Point,	2 days	Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Veterans Administration Hospital	RFD # 2 Box # 105A		

3. NAME OF DECEASED (Type or print)	First Robert	Middle O.	Last Swift	4. DATE OF DEATH January 8 19 60
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-07	9. AGE (in years from birthday) 52 yrs.	IF UNDER 1YEAR Months Days	IF UNDER 24 HRS. Hours Min.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Not Ascertainable	11. BIRTHPLACE (State or foreign country) Buffalo, New York	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME Charles A. Swift	14. MOTHER'S MAIDEN NAME Winifred Johnson
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW II	17. INFORMANT Margaret Swift (W) RFD # 2 Box 105A Street, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>736.0</i> DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause last.</i> (b) DUE TO <i>Left subdural hemorrhage</i> (c) DUE TO <i>Right: sub arachnoid hemorrhage mid line</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Numerous contusions over body, ulcer at the pyloris with hemorrhage in the intestines</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently was beaten				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1-5 1960 p. m.	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In house	20f. (City or town) Street, Harford	(County) Md.	(State)

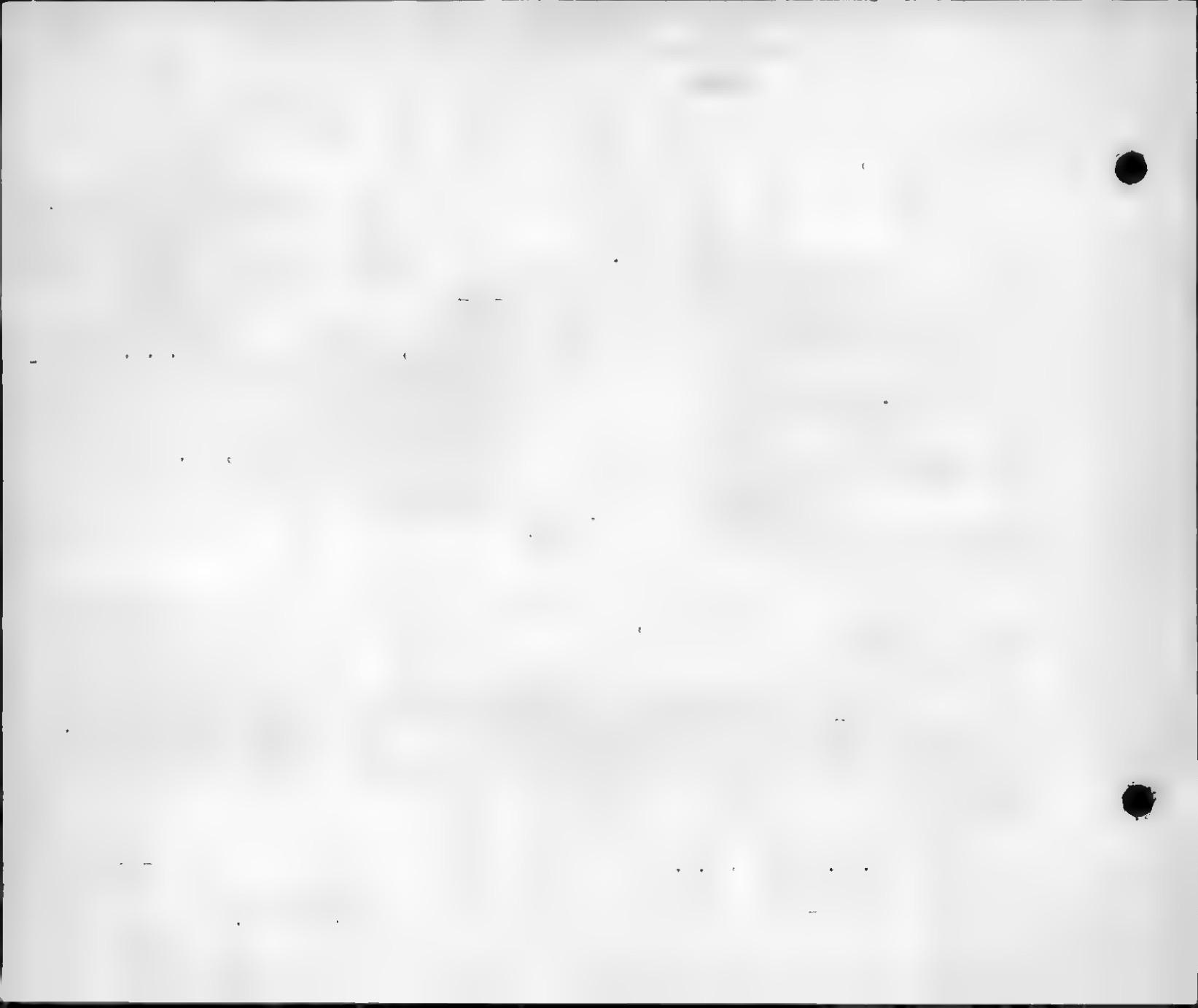
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE: <i>R. C. Dodson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 1-9-60
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EXAMINER'S NAME (Type) R. C. DODSON, M. D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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22o. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 1-9-60	22c. NAME OF CEMETERY OR CREMATORIUM Southern Cemetery	22d. LOCATION (City, town, or county) Dublin, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey, Arlington Md</i>	ADDRESS	24a. REC'D BY REGISTRAR JAN 12 '60 DATE	24b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0564 CERTIFICATE OF DEATH

Reg. Dist. No.

00561

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>Pa</u>		b. COUNTY <u>Lancaster</u>			
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <u>Rising Sun, Md.</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town] <u>rural, Colorado</u>		d. STREET ADDRESS <u>Kirkwood</u>			
d. NAME OF HOSPITAL [If not in hospital, give street address] <u>Grayhead Nursing Home</u>				d. STREET ADDRESS <u>Kirkwood</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary W. Swisher</u>		First	Middle	Last	4. DATE OF DEATH <u>Jan. 18</u>	Month	Day	Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct. 14, 1870</u>	C. AGE (In years lost birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE [State or foreign country] <u>North East, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Christopher Swisher</u>		14. MOTHER'S MAIDEN NAME <u>Sarah M. Flett</u>		Address <u>Kirkwood, Pa</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Swisher, Kirkwood, Pa</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>none</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] <u>—</u>							
20c. TIME OF INJURY Month, Doy, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u>		(County) <u>—</u>	(State) <u>—</u>
21. I certify that I attended the deceased from <u>3/16</u> , 19 <u>54</u> , to <u>1/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>11/8</u> , 19 <u>60</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Neil Taylor</u>		M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>		DATE SIGNED <u>1/20/60</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor, Dr. M.D.</u>		Rising Sun, Md							
22a. BURIAL, CREMATION, REMOVALS (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/60</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Oxford Cem.</u>		22d. LOCATION (City, town, or county) <u>Oxford, Chester Co</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed</u>		ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours of the death.

ST. DOMINIC'S HIGH SCHOOL, KARASIAHATTA, GULBARGA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md.		c. LENGTH OF STAY IN 1b Enroute		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE N.Y.		b. COUNTY N.Y.	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Congers		d. STREET ADDRESS 140 Wells Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jeanne	Middle C	Vechio	Lost	4. DATE OF DEATH Month Day Year Jan. 23 1960	Month	Day	Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-4-1931	9. AGE (in years last birthday) 28 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Model		10b. KIND OF BUSINESS OR INDUSTRY Modeling		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Anthony Vecchio		14. MOTHER'S MAIDEN NAME Louis Scalero							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Louis Scalero, Congers, N.Y.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractures of left humerus, left temporal bone with brain tissue exposed frontal bone and occipital bone and left clavicle. Laceration 6 inches long top of head. Both legs lacerated at knees 3 inches long abrasions hand and face. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 816X DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car was hit by another one driving in wrong lane 20c. TIME OF INJURY Month, Day, Year Hour 0:35 m. 1 23 1960 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> Route 40 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elkton Cecil Md. 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>R.C. Dodson</i>		DATE SIGNED 1-21-60							
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-24-60		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Elkton, Md.		22d. LOCATION (City, town, or county) (State) New York City, N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS <i>Douglas Lee</i>		24a. REC'D BY REGISTRAR Chas. S. Hanna		24b. REGISTRAR'S SIGNATURE <i>Chas. S. Hanna</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certifying physician writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the registrar prior to burial; cremation, or removal.

REVIEW OF EXAMINER'S DESIGNATION OF DATA

Designation	Number	Date	Comments
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